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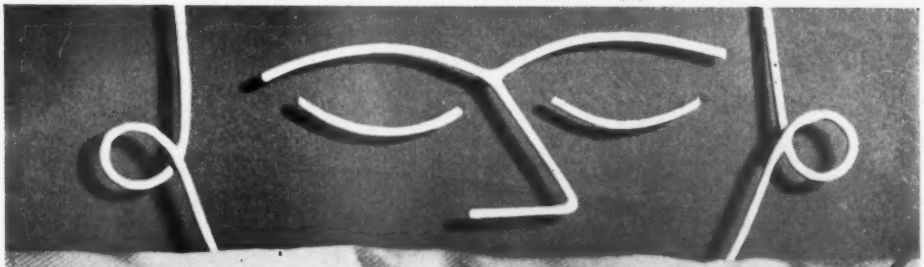

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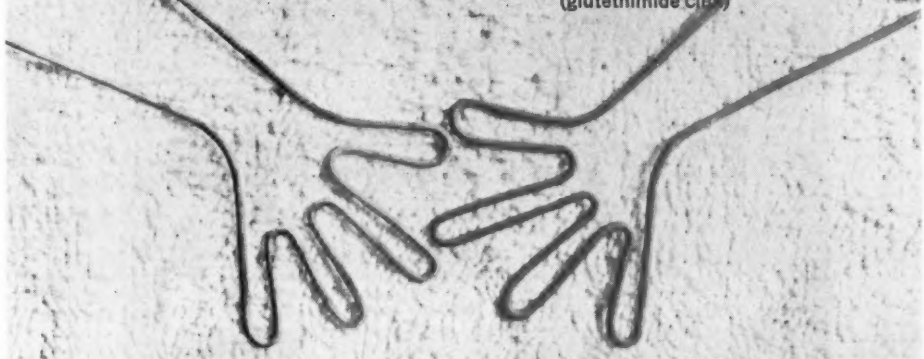

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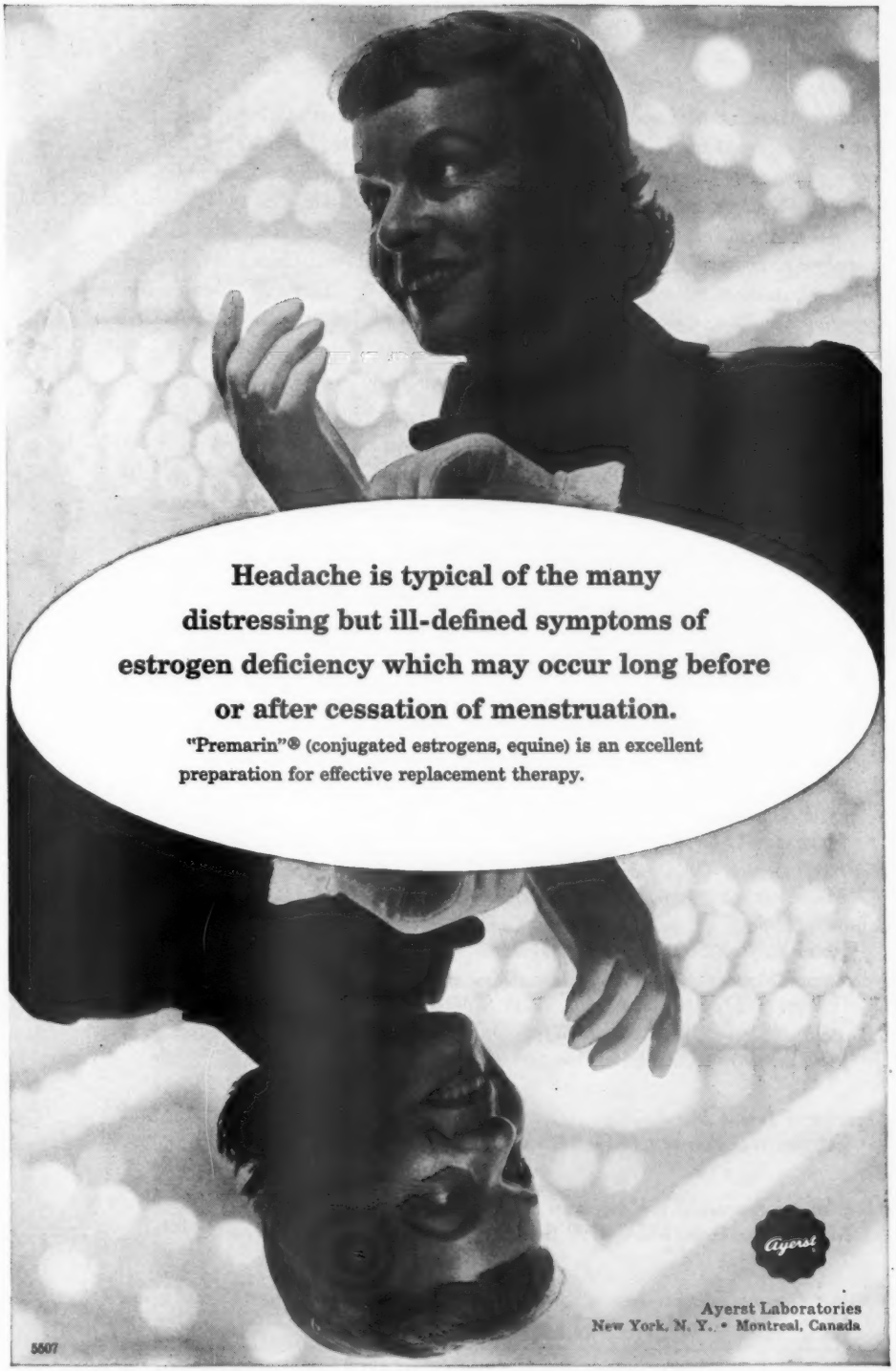
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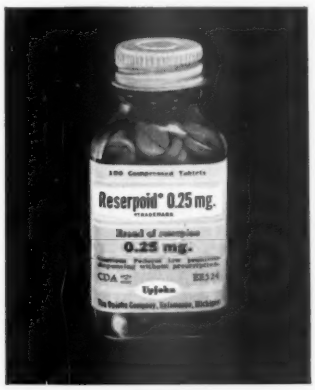

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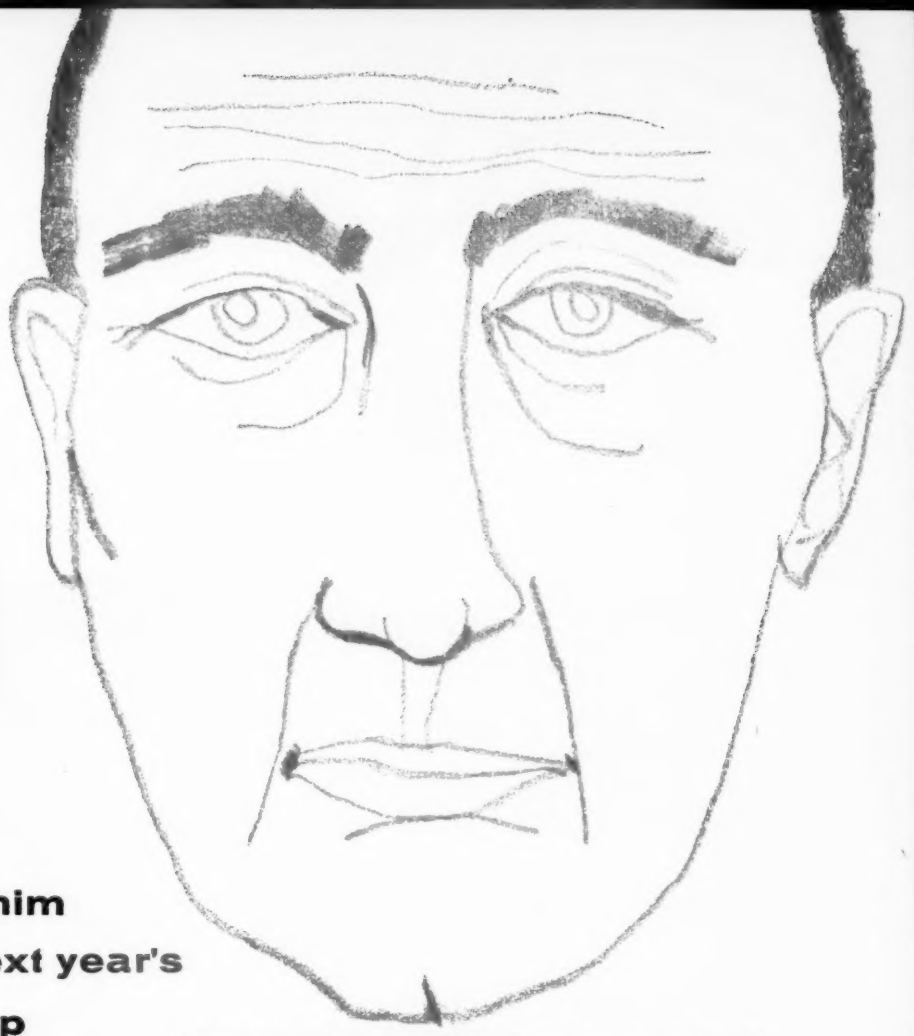

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(Continued on page 16)

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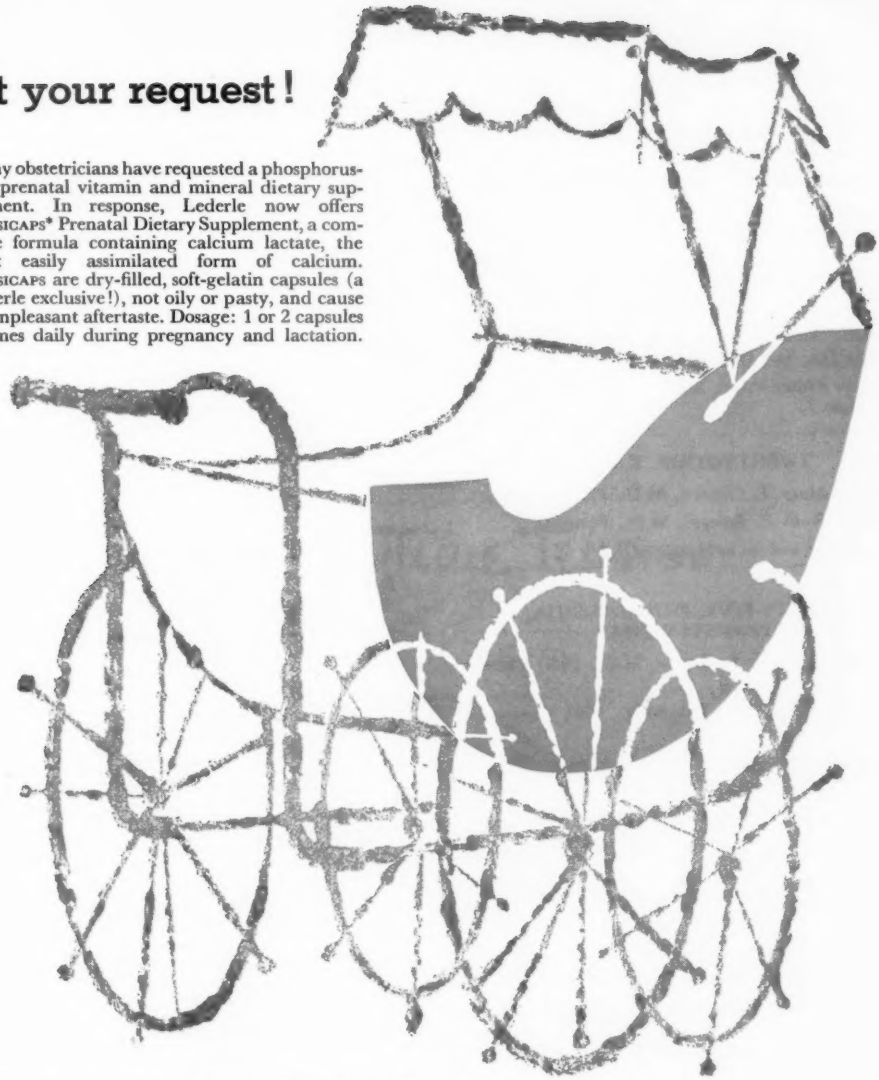

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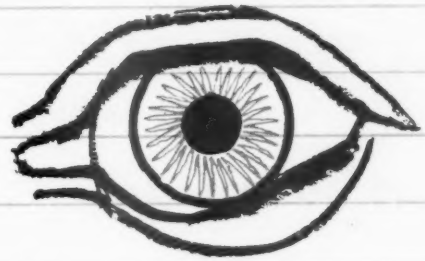

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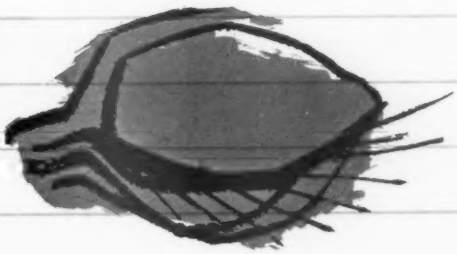

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TOWARD REHABILITATION OF KOREAN CHILDREN

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NORWAY CATERS TO OLD FOLKS AT HOME

Old folks living at home in Norway benefit from a variety of services, including nursing, medical advice and health control, prepared meals, baths, foot care, laundering, house cleaning, and correspondence, all provided by health and welfare centers established in the past few years by the joint efforts of the Norwegian Tuberculosis Association and the Norwegian Women's Health Association, in co-operation with other organizations and with municipalities. Two experimental health and welfare centers in Oslo have proved most successful, and plans are afoot to extend the service throughout the country. Norway is making a novel approach to the problems of the aged in trying to meet every need of these old people. Some of the aged also need guidance on budgeting or assistance in finding suitable employment. In addition, the centers help to break the loneliness of the aged by arranging social get-togethers, home visits, excursions, and extended stays at vacation homes. The accent throughout is on activization and the development of new interests.

This phase of geriatric care was reported by a committee named in 1950 by the Norwegian Tuberculosis Association and the Norwegian Women's Health Association in a comprehensive study dealing with the diseases, economy, and employment opportunities of Norway's aged. The report is published as the first volume in a series of Norwegian gerontological studies and will be followed soon by a second volume on the health and living conditions of the same age group. The main recommendation in the published report calls for concerted efforts at the local level to consider the problems as a whole, with emphasis on more health and welfare centers for the aged. Medical care for the aged calls for far greater emphasis on psychology and social welfare than is needed in the case of the younger generation. Medical and social welfare programs are equally essential and one depends on the other. To recognize this is one of the most important prerequisites in solving the problems of old age, the report says.

Norway is one of many countries faced with the problem of greater longevity. A Norwegian man who has reached 70 may expect to live another 11 years, while a woman of the same age is likely to live an additional 12 years. As a basic step toward working out practical solutions, the report suggests the establishment of a health and welfare committee for the aged in every municipality, which should study all aspects of the old folks' problems, make a complete survey of existing provisions, and plan new projects as required. There should be no suggestion of charity, and every effort must be made to effect a greater adjustment between the aged and society. Inasmuch as old people often develop ailments because they are alone, the provision of adequate social contacts should be an important part of the medical treatment. The fundamental view of the committee members is that elderly people should be enabled to live in their own homes as long as possible, partly because that is their own wish, and partly because their number is growing ever larger. The committee also states that many who receive institutional care should be in nursing homes and that many more such homes are needed, both in town and country. (Extracted from *News of Norway,* 12: 47, '55.)

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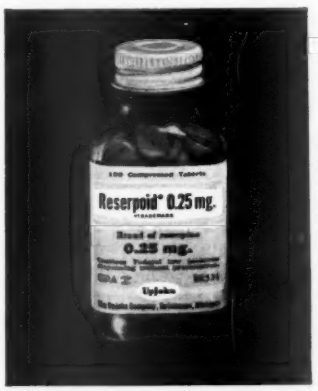

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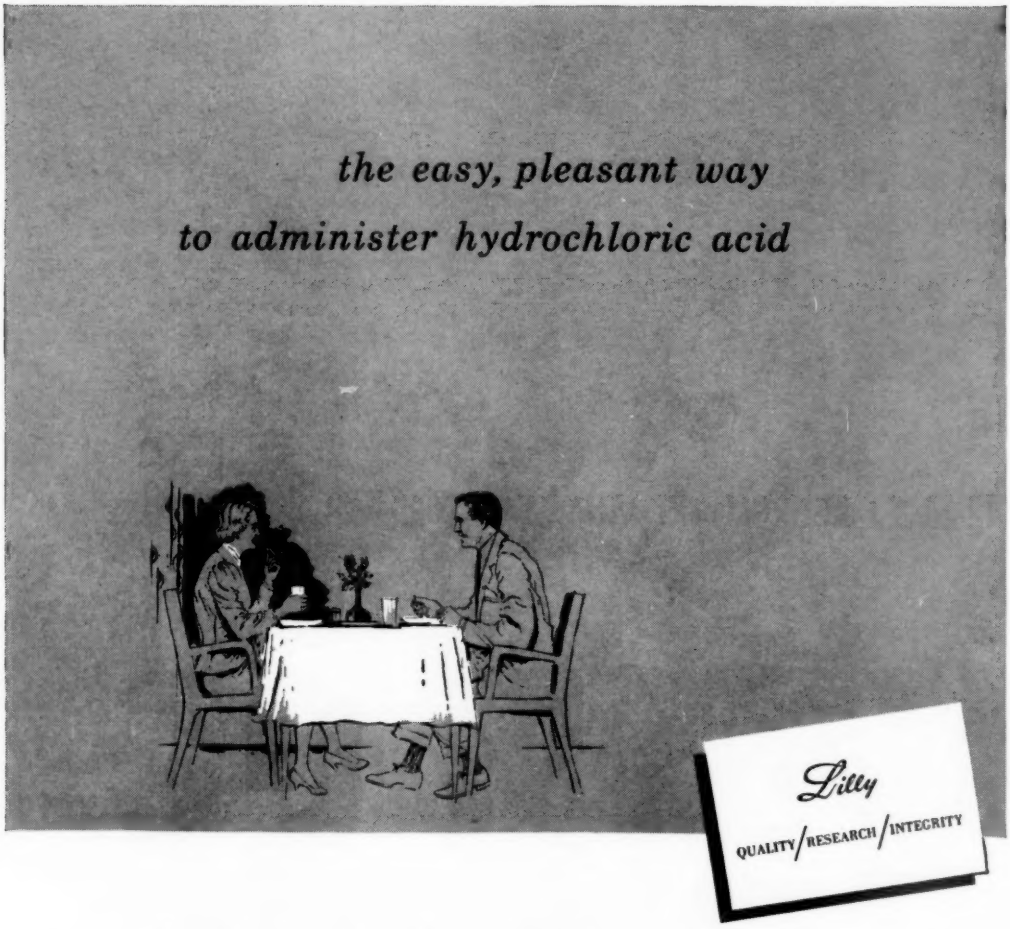

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Journal of the
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VOLUME 10 MAY 1955 NUMBER 5

Pediatric Allergy

Elizabeth B. Brown, M.D.

THE PROBLEM OF ALLERGY in pediatrics is not too different from the problem in the adult. There are, of course, advantages and disadvantages in the handling of both types.

The infant's or young child's allergic manifestations are apt to be more simple and therefore more easily diagnosed. The child responds to treatment more readily than the adult. In children we do not see irreversible lesions because these lesions develop only after many months or years of uncontrolled or neglected chronic disease.

As far as we know, infants are not born sensitive. Studies made on cord blood do not show reactions on passive transfer.[1,2,3] Although protein antigens have passed the placental barrier, no active sensitization has been developed by the fetus, nor can an allergic mother passively sensitize a fetus with sensitizing antibodies. Infants develop sensitization shortly after birth; within a few days, weeks, or months. The earliest sensitizations developed are usually to foods.

Cooke and Vander Veer[4] have shown that babies with a bilateral family history of allergy develop clinical symptoms at a much earlier age than those in whom the hereditary factor is unilateral. A child does not necessarily inherit sensitivities identical to those of its parents. The hereditary factor is a tendency rather than a specific sensitivity. What determines the shock organ or the particular symptom complex is not known.

Wiener[5] has pointed out that antibodies of identical specificity may exist in several molecular forms, of which only two principal forms need be taken into account for practical purposes, agglutinating (bivalent) antibodies and blocking (univalent) antibodies. There is evidence to indicate that univalent antibodies are responsible for one's immunity to microorganisms and that bivalent antibodies appear to be the basis for the various allergic phenomena: hay fever, asthma, and eczema. Univalent antibacterial and antitoxic antibodies, by their ability to traverse the placental barrier, are largely responsible for a baby's neonatal immunity. Evidence to support this is that the univalent Rh antibody causes erythroblastosis fetalis.

Newborn infants are relatively incapable of producing antibodies and depend for their immunity largely on antibodies passively acquired from the mother. Immune antibodies appear to be gamma globulin. The gamma globulin peak in newborn babies is about the same as in the mother; it declines gradually as the baby grows older and reaches a minimum at three to four months of age, and then gradually rises again. This is taken to indicate that most of the gamma globulin of the newborn has been passively derived from the mother. The fact that the gamma globulin peak does not decline as rapidly as the titer of the passively acquired antibodies suggests that even shortly after birth the infant is already beginning to produce some of its own gamma globulin.

Dr. Brown is Assistant Professor of Medicine, Hahnemann Medical College; Chief of Allergy, Hahnemann Medical College and Hospital; and Acting Chief of Pediatric Allergy, Philadelphia General Hospital, Philadelphia, Pennsylvania.

There is a short period during which the infant is prone to allergic disorders caused by foods, inhalants, and microorganisms. Presumably, in most babies, allergic manifestations do not appear because blocking antibodies passively acquired from the mother tide the babies over until they form their own univalent antibodies. In the baby who develops eczema, it is likely that specific blocking antibodies were lacking from the mother's serum or the baby was constitutionally predisposed to produce excessive titers of reagins (bivalent antibodies).[5] This would explain the usual time of onset of infantile eczema at 2 or 3 months of age and the spontaneous recovery which generally takes place at the age of 2 years. By this time the baby has, as a rule, formed adequate amounts of immune (blocking) antibodies.

The logical treatment in infantile eczema is to immunize the affected babies. It may be worth while, in selected cases, to try injections of immune globulin, which, theoretically, could tide the baby over until such time as he develops his own immune antibodies. Wiener[5] treated 2 cases of intractable eczema with repeated injections of immune globulin and the skin cleared.

One must always take into consideration that there exist individual differences in the constitutional response to the same antigen-antibody combination. Allergic individuals constitute a selected group whose immune reactions differ from the norm, and there are wide variations in the responses of different individuals, both normal and allergic. Therefore, each problem must be individualized, and in selecting the best treatment course for a patient one must resort to trial and error to a certain degree.

Many authors have claimed that allergic individuals are superior mentally and are emotionally less stable than normal people.[6,7,8,9,10] Others, however, have found that allergic children reacted no differently mentally or emotionally from normal children.[11] We have, therefore, no evidence to show that psychic factors are capable of producing allergic syndromes in children. However, psychic factors can affect the allergic child, just as they affect anyone else; and they must be recognized as such in the management of these patients. The patient as a whole must be treated. Psychic factors are important but no more so than any other factor which may contribute to the patient's lack of well-being, such as nutritional, vitamin, or hormonal deficiency.

Allergies in Infancy

During the first few years of life there are three major allergic conditions: 1) systemic reactions, 2) allergic dermatitis (infantile eczema), and 3) bronchial asthma.

Systemic Reactions. Systemic reactions may be acute or chronic. The acute reactions follow the ingestion of allergenic foods and there may be edema of the lips, face, and tongue; vomiting, urticaria, asthma, abdominal pain, and diarrhea. All these symptoms may be present in an individual, singly, or in any combination. Usually these sensitizations are lost by the age of 5 or 6 years, but in instances they persist through adult life. They should not be regarded lightly and dismissed with the observation that the child will outgrow the condition.

The chronic reactions are caused by food or low grade infection. The manifestations are the same as in the acute attacks, although not as dramatic.

Allergic Dermatitis. The condition of allergic dermatitis is a characteristic lesion of the skin, usually face and scalp, sometimes arms and legs, and at times it may cover the entire body. Most of these infants have a family history of allergy. About one half of these patients give positive cutaneous wheal reactions to many allergens, including foods and inhalants. The clinical significance of these reactions is not known and they yield little or no information as to the origin of the lesion. It is unwise to maintain these patients on a deficient diet because of positive skin tests. They should only be restricted as to foods that can be proven to be clinically allergenic.

Asthma. In the rare case. asthma may result from an acute systemic food reaction. The most important causative factor is infection. Some pediatricians call this condition asthmatic bronchitis. Others call it infective asthma. Both names describe the same condition; it is precipitated by an acute infection. These patients are often sensitive to other agents such as foods or inhalants. The history is quite typical. The patient has frequent upper respiratory infections followed by episodes of severe dyspnea, expiratory wheezing, and cough. Usually these attacks are accompanied by fever, leukocytosis, and blood eosinophilia. In the intervals between attacks the patient is entirely free from allergic symptoms. As the child grows older, he may develop allergies to inhalants such as dusts, pollens, molds, and danders. Then, of course, he may have attacks of bronchial asthma when he does not have a respiratory infection.

Other causes of dyspnea in the infant, such as thymic enlargement or the presence of a foreign body, obviously should be ruled out.

Allergies in Older Children

The allergic infant does not cease to be an allergic individual when he ceases to be an infant. He may carry over the same allergic manifestations that he had in infancy or he may have had a spontaneous remission and be symptom-free. He is, however, still a potentially allergic person. More than 50 percent of these children develop symptoms of the same or different type, but in reaction to a different allergen. In this age group, inhalant allergens play the principal role, with infection secondary, and foods rarely. The common clinical allergies in children are seasonal and perennial rhinitis, asthma, and dermatitis. Urticaria and angioneuro-edema occur less frequently; but when they do, they may pose very serious problems.

Seasonal Allergic Rhinitis (Pollinosis). Pollinosis is caused in the early spring by tree pollens, later by grasses, and in the fall by weeds and seasonal molds. The origin in a given case is determined by the history and skin testing.

Perennial Allergic Rhinitis (Atopic Rhinitis, Vasomotor Rhinitis). The causes in cases of perennial allergic rhinitis may be inhalants such as dusts, molds, epidermals; foods, drugs, or infection. Bacterial infection very often plays a major role in these cases either as a primary factor or as a secondary invader in tissue sensitized by other allergens.

Bronchial Asthma in Children. There is a mistaken notion that children will outgrow asthma; nothing could be further from the truth. These children should be diagnosed and treated as soon as there is a suggestion that asthma may develop. It can often be foretold in children allergically predisposed by heredity, who have frequent respiratory infections and persistent cough. Children with chronic allergic rhinitis are often predisposed to asthma. By intensive treatment in this age group we can prevent the condition from becoming long standing and complicated. We will also prevent the irreversible pathologic changes which inevitably occur in neglected cases.

We must, of course, rule out the following conditions: acute and chronic tracheobronchitis, foreign bodies, tumors, enlarged thymus, substernal thyroid, tuberculosis, bronchiectasis, pneumonia, and cardiac decompensation. All of these conditions may, of course, occur concomitantly with bronchial asthma, and it is necessary that the appropriate clinical and laboratory procedures be carried out to determine with what one is dealing.

Löffler's Syndrome. Löffler's syndrome occurs in allergic children, particularly asthmatic children, and is characterized by an extremely high blood eosinophilia (10 to 60 percent). Transitory consolidations of the lung occur. Some cases are benign. Others are associated with at least some of the characteristics of periarteritis nodosa or lupus disseminatus. Usually they present a picture of severe bacterial allergy.

Infection in the Allergic Child. Several patterns occur with infection in the allergic child. These suggest many clinical applications.[12] Infection may aggravate an already existing allergy. Allergic manifestations may be in remittance during an acute infection. Allergic manifestations may be the direct result of hypersensitivity to bacteria or bacterial products. In general, it may be said that the bacterial allergies are not properly recognized, appreciated, or managed. Sinusitis in children is common, as Dean[13] and others[14] have shown.

Diagnosis of Allergy in Children

History. The history comes first and is most important. Very often clues can be brought to light with a thorough and exhaustive history, which should include age at onset, dietary history from birth, history of any gastrointestinal upsets, skin rashes, chronic or recurrent respiratory infection, and environmental history, such as type of heating system and exposure to pets and plants. Family history of allergy is important; so are seasonal aggravation and change of climate aggravation or remission. Social and emotional factors should be investigated.

Physical Examination. There should be a complete examination, with special attention to the nose and throat; teeth, lungs, and skin. Any deficiency diseases such as hypothyroidism or hyponutrition should be corrected.

Laboratory Examinations. A complete blood count should always be done, to determine eosinophilia and possibility of anemia, lymphocytosis, and so forth. Sedimentation rate, Wassermann test, and blood chemistry determinations should be done when indicated by history or physical findings. Chest films should be done routinely. Sinuses, teeth, and gastrointestinal tract roentgenograms should be done as necessary to confirm an opinion or to rule out other conditions.

Skin Tests. Skin tests may be either scratch or intracutaneous, the latter being preferred by most allergists. Patch tests are occasionally useful for those substances which do not lend themselves to the other methods. However, patch tests should be limited, because they are capable of causing sensitization. Skin tests are still only laboratory aids and do not in themselves constitute the diagnosis. They give us clues with which to work and the results must be correlated with the clinical picture. Skin tests for inhalants are much more likely to be significant than those for foods. Skin tests are of importance clinically only if it can definitely be shown that contact with the offending food or inhalant or infectant is capable of precipitating the clinical syndrome from which the child suffers. Swineford[15] states that cutaneous reactions to foods and inhalants can indicate nothing more definite than preclinical, subclinical, clinical, or postclinical sensitivity. Of itself, a positive cutaneous reaction may not be taken as demonstrating a causal relationship to any clinical syndrome.

Diet Trials. When a food sensitivity is suspected, elimination or trial diets will frequently yield valuable information.

Treatment

Treatment may be divided into two parts; symptomatic and specific. Symptomatic treatment is used 1) to control acute attacks, 2) as temporary treatment while the patient is being studied, and 3) as adjuvant therapy where specific treatment does not control the patient's symptoms completely.

1. Antihistamines may be used for any allergic manifestation. However, it is better to give some other type of drug for asthma. Antihistamines tend to dry secretions. These drugs must be individualized for each patient since there is a great deal of variation in effectiveness, tolerance, and side effects in each patient.

2. Ephedrine may be given orally in doses of ⅛ to ⅜ grains every 3 to 4 hours. One percent ephedrine may be used in nose drops either in isotonic saline or in combination with other decongestants, antibiotics, or aromatics.

3. Epinephrine (1:1000 aqueous) may be given subcutaneously. Small doses (0.1 to 0.3 cc.) are just as effective as larger doses and may be repeated frequently. Side reactions are much less annoying with a small dose. Epinephrine may be given in gelatin or in oil for a more prolonged effect. Epinephrine and related drugs (neo-synephrine®, vaponephrine, and isuprel®) may also be used by nebulization.

4. Aminophylline is a very valuable drug for the treatment of asthma. It may be given orally (1 to 3 grains every 4 hours); intramuscularly (3¾ grains every 3 to 4 hours); by rectal suppository (3¾ to 7 grains); or intravenously (3¾ to 7 grains, well diluted and very slowly).

5. Expectorants combining ammonium chloride, iodides, ephedrine or related drugs are very effective in loosening mucous secretions. Ipecac is also a valuable drug for this purpose. It is given in repeated small doses (½ to 1 teaspoonful of the syrup) every 3 to 4 hours. It may also be used as an emetic by giving the same dose every 15 minutes until emesis. There is an occasional case of sensitization to ipecac. It has been known to precipitate cyclic vomiting.

6. Sedatives should always be given in small doses, with caution not to use drugs that will cause respiratory depression. Bromides or barbiturates may be given to allay anxiety. Paraldehyde, orally or rectally, may be helpful. Demerol®, in selected cases and in small doses, particularly in status asthmaticus, is used to relax and to control the severely apprehensive patient. Chloral hydrate, either orally or rectally, is often very effective.

7. Khellin,[16] given intramuscularly in doses of 50 to 100 mg., has proved to be very helpful in controlling chronic asthma. The action is similar to that of aminophylline, but it lasts over a period of several days to a week or two.

8. ACTH and cortisone are very effective, but their use should be reserved for those cases which fail to respond to other therapy, or for self-limiting allergic conditions. Doses must be individualized. Side effects may be serious, but are usually reversible following discontinuance of the drugs. These drugs do not replace studies, elimination, injections, medication, and other therapy.[17] Because of their greater recuperative powers, Glaser[18] feels that in the use of these drugs as adjuvant therapy infants and children have a better chance of ultimate relief than adults. In the administration of these hormones, Glaser recommends the addition of 2 mg. of potassium with each dose.

Specific treatment should always be carried out whenever possible. It consists of the following. 1. Avoidance of the allergen, such as removal from the environment (feathers, pets, toys, and so forth), change of climate (to pollen-free areas) when practical. 2. Specific hyposensitization: gradually increasing injections with dust, mold, pollen extracts, or bacterial antigens. Best results are obtained with

extracts that are prepared especially for the patient. Doses should be individualized, and not left to the discretion of an office assistant. Bacterial antigens are always more effective when autogenous. 3. Removal of foci of infection, when present. 4. Antibiotic therapy for acute infection. This is not warranted to control chronic infection; more specific measures should be instituted to eradicate the infecting agent. The indiscriminate use of antibiotics[19] leads to increasing tolerance to these drugs by bacteria, as well as hypersensitivity in the patient. We also run the risk of disturbing the normal bacterial flora in both the respiratory and gastrointestinal tracts by excessive use of antibiotics.

Prognosis

In no phase of allergy are the results of proper therapy more gratifying than in pediatric practice. Even though sensitization cannot often be prevented, these patients can be managed through the important years of their growth and development. The prognosis is good for those who are properly managed. By treating each allergic manifestation as it comes along, we may be preventing more serious and more complicated symptoms from appearing. It is a fallacy that children will outgrow their allergies. This is a belief too often followed and its practice frequently leads to serious difficulty.

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The Proteins

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UNTIL RECENTLY, PROTEIN metabolism has been studied chiefly by means of nitrogen balance, or the difference between the dietary nitrogen intake and nitrogen excretion in urine and feces. A more satisfactory method of study consists in labeling compounds by using isotopes of carbon, hydrogen, oxygen, nitrogen, sulfur, and phosphorus. Living organisms seem unable to discriminate between stable and radioactive elements, but use them alike. When amino acids containing isotopes are introduced into the body, they appear in all tissues, and in the excreta.[1] This method is widely used at present.

Proteins are the chief nitrogenous constituents of the tissues of the body and of the food we eat. The stores of protein are in the tissues and in the body fluids.

The number of possible proteins is exceedingly large. The known ones consist of combinations of 23 alpha amino acids, united by means of carboxyl and amino groups. They may be simple proteins, composed of amino acids only, or conjugated proteins, composed of amino acids and other compounds, such as nucleic acids and lipids.[2]

Of the 23 known alpha amino acids, 8 have been found to be "essential" to man. An essential amino acid is one which cannot be synthesized by the body in sufficient quantities to meet its needs. Requirements vary in amount with the physiologic condition (such as age and state of nutrition). The essential acids are: valine, methionine, threonine, leucine, isoleucine, phenylalanine, tryptophan, and lysine. The exclusion of any one of these from the diet is followed by a negative nitrogen balance.[3a] The nutritive value of any particular protein is limited by the essential amino acid that is present in the lowest concentration.

The term "essential" may not be a happy choice; in no sense does it imply that the so-called "nonessential" amino acids are not needed. The diet must contain an abundant supply of protein, so that the body may synthesize the 15 known nonessential amino acids, in such generous amounts as are necessary, if they are not present in the proteins eaten.

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Fate of Absorbed Amino Acids

1. Amino acids needed to form any tissue protein are removed from the blood and built into the protein characteristic for that tissue. They are required for growth in the young and for repair in the adult. In turn, amino acids are constantly liberated into the blood from tissue proteins which are broken down during normal wear and tear. The amino group in one amino acid may shift about; the component amino acids may shift about within one protein molecule. In addition, there may be shifting of amino acids, and indeed of whole protein molecules, from plasma to tissue protein and vice versa.[4] The amino acids which are most active in the continuous interchange of nitrogen atoms are the two dicarboxylic acids, glutamic and aspartic, although they are listed as "nonessential." These are especially important in deamination and transamination.

2. The liver removes amino acids from the blood and synthesizes them into many of the plasma proteins.[5] It likewise synthesizes proteins and stores them in a labile state in the form of granules in the cytoplasm of liver cells.

3. In addition to tissue, plasma, and liver proteins, many other nitrogenous substances are synthesized by various cells of the body; these substances include hormones, enzymes, purines, pyrimidines, nitrogenous bases, creatine, and antibodies. An amino acid, either absorbed from the intestine or added to the blood as a result of catabolic processes in tissues, may be used in various ways before it eventually leaves the body as waste.[2,6]

4. Amino acids are subjected to oxidative deamination or to deamination by transamination, with the formation of keto acids, which then follow one of the following paths of metabolism: a) oxidation of the keto acid by the pyruvic acid pathway (called antiketogenic); b) oxidation of the keto acid by way of aceto-acetic acid (called ketogenic); and c) synthesis of the keto acid to glycogen (called gluconeogenesis).

The Dynamic Protein Pool

Whipple and his associates[7] first called attention to the dynamic balance between ingested amino acids and those in the liver and tissues. There is a

large protein pool in the body, which includes circulating plasma proteins and proteins of the liver and tissues. The diet, the liver, and the tissues contribute to this pool, and any cell of the body which needs protein can withdraw what it needs. The circulating plasma protein and amino acids are the medium of exchange.[8]

In various tissues, a particular amino acid can have different rates of exchange with the plasma and with its precursors and metabolic products in the cells. The rate of exchange is determined by the activity of constituent cells in any tissue.[9] New amino acids are constantly joining proteins and old amino acids are leaving, although the total number remains constant in any one protein. The amino acids of liver, plasma, and tissue proteins can be quickly replaced by new amino acids of the diet, since the peptide bonds of proteins rapidly open and close.[2] The various types of exchanges have been identified by means of isotopes.

The concept which we should have is that of large, complex molecules and their components, constantly taking part in rapid chemical reactions. Linkages open, and the fragments liberated by metabolic processes merge with those derived from other large molecules from other tissues, and with those absorbed from the intestinal tract. It is impossible to distinguish the source of the various components of the protein pool, since all of them are in dynamic equilibrium.[1]

Functions of the Proteins

Proteins perform many functions[10,11,12] in the body. Albumin, the smallest of the plasma proteins, with a molecular weight of about 69,000, is important in maintenance and stabilization of the blood volume. In other words, albumin serves osmotic functions. Prothrombin and fibrinogen are concerned with the coagulation of the blood. The alpha and beta globulins are important in the transport of lipids; they serve to hold in solution relatively large amounts of substances which would otherwise be practically insoluble in an aqueous salt solution. In general, antibody activity is associated with gamma globulin.

Antibodies, antigens, enzymes, some hormones, toxins, viruses, and genes are all believed to be simple or conjugated proteins, with a high degree of specificity. Biologic activity probably depends on the configuration of all or part of the molecule. The steric pattern is undoubtedly important. Du Vigneaud,[13a,13b] who determined the composition of vasopressin and oxytocin, found that a difference of two amino acids was important in the particular properties of these hormones.

Distribution of Proteins within Cells

Some of the protein within cells is combined with nucleic acids in the form of nucleoprotein.[2,3b,14,15,16]

In the nucleus, protein is combined with both RNA (ribonucleic acid) and DNA (desoxyribose nucleic acid). The chromosomes are extremely rich in DNA, which doubles in amount during mitosis. The nucleus is thought to be the center for the formation of protein, which takes place through the mediation of nucleic acids. They are abundant in cells in which rapid protein synthesis is taking place, not only for reproduction of gene proteins, but also for cytoplasmic proteins for growth or secretion of digestive enzymes. The RNA of the nucleus incorporates isotopes such as P^{32} and C^{14} much more rapidly than does the RNA of the cytoplasm, and it is the nucleus which is essential for the maintenance of an adequate store of cytoplasmic RNA. It has been suggested that the sequence of bases in DNA (which is now known) is in some way a code for the sequence of amino acids in the polypeptide chains of proteins which cells must produce.

In the cytoplasm, protein is a constituent of mitochondria (or microsomes). The RNA of the mitochondria must be intact for protein synthesis to occur, as shown by radioactive isotopes (glycine containing N^{15} and alanine containing C^{14}). Mitochondria have been called the power plants of cells and one mitochondrion can accommodate at least one million protein molecules.

Results of Protein Depletion

The consequences of protein and amino acid deficiency have been described by Cannon.[17] Basic defects include muscular weakness, weight loss, hypoproteinemia, anemia, and a reduced ability to form certain hormones and enzymes, since protein is needed to maintain all of these at a normal level. Decreased resistance to infection is caused by the following: leukopenia with decreased phagocytic potentialities,[18] deterioration of natural immunity, and lymphoid depletion with decreased capacity to form antibodies. All of these reduce the factor of safety. They are responsible for slow wound healing and the fact that protein depleted patients are poor surgical risks.

A negative nitrogen balance, or protein deficiency, occurs with inadequate intake, incomplete absorption, increased catabolism (in fevers), impaired synthesis (in liver disease), and with increased loss. An excessive loss of albumin occurs in nephrosis.[11] There may be a defect in the reabsorption of amino acids by the kidney tubules in Wilson's disease.[19] There is an increase in amino acid excretion also in

Fanconi's syndrome,[20,21] probably owing to dysfunction of the proximal tubules.

The liver is especially vulnerable to toxic agents whenever its store of protein is depleted.[4]

Protein Therapy

Not only is adequate protein needed in the diet, but adequate caloric intake is also essential,[4] otherwise the amino acids will be used immediately to produce energy instead of serving as sources of plasma protein, liver protein, tissue protein, hormones, and enzymes. If it is impossible to take protein by mouth, parenteral administration is effective. The administration of the essential amino acids parenterally as the sole source of nitrogen has been found adequate for plasma protein formation for limited periods.[22] Synthetic mixtures of amino acids are more palatable than protein digests, when given orally. Preoperative protein repletion of patients enables them to withstand operations better.[23] The dietary treatment of cirrhosis leads to clinical improvement after several months.[24]

Observations

There is increased globulin in the blood in multiple myeloma.

The plasma albumin is decreased in nephrosis (increased loss), extensive burns (increased loss), cirrhosis (synthesizing defect), and malnutrition.

An increase in alpha globulin in plasma constitutes a consistent manifestation of an acute febrile disease.

An increase in beta globulin is found in association with an accumulation of lipids and lipoproteins in the plasma.

Fibrinogen in plasma is increased in acute infections, nephrosis, pregnancy, and after roentgen radiation. It accelerates the speed of sedimentation of red blood corpuscles.

Gamma globulin is increased in many chronic infections.

In conclusion it may be stated that we are just at the threshold of the study of the physiologic importance of the proteins. Their place in human nutrition problems is ably reviewed by Flodin.[25]

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Immediate Care and Resuscitation of the Newborn Infant

Elizabeth S. Waugh, M.D.

THE IMMEDIATE CARE of the newborn infant is the duty and privilege of the obstetrician. Few hospitals are fortunate enough to have a team of trained anesthesiologists who are skilled in the resuscitation of the baby. In most instances, the obstetrician must assume this responsibility and train the intern or resident in obstetrics to do likewise. The problem would be simple indeed were it not for the too frequent cases of anoxia and asphyxia neonatorum. In Philadelphia, a study of the neonatal and maternal mortality rates for 1950, 1951, 1952, and 1953 shows (Table I):

TABLE I. NEONATAL AND MATERNAL MORTALITY*

Year	Deaths under 28 Days	Rate per 1,000 Live Births	Maternal Deaths	Rate per 1,000 Live Births
1950	1,058	22.3	48	1.0
1951	1,054	20.9	40	0.8
1952	1,113	21.5	44	0.9
1953	1,181	22.8	36	0.7

The causes of neonatal mortality for the year 1953 are listed as follows[1] (Table II):

TABLE II. NEONATAL MORTALITY FOR 1953*

Cause of Death—Total Deaths for Year under 1 Month		
Meningococcal infections		1
Congenital malformations		150
Intracranial and spinal injuries at birth	118	
Other birth injuries	130	248
Postnatal asphyxia & atelectasis		220
Infections of the newborn		73
Other diseases peculiar to early infancy		118
Immaturity, unqualified		341
Violent deaths		8
Other causes of death		22
Total deaths under 1 month, 1953		1,181
Rate per 1,000 live births		22.8

The causes of asphyxia neonatorum have been listed by Little and Tovell as follows[2] (Table III):

TABLE III. INCREASED INCIDENCE OF ASPHYXIA NEONATORUM**

Maternal Causes

Diseases of circulatory system, pulmonary system, and genitourinary and gastrointestinal tracts
Infections
Anemia
Metabolic diseases, such as diabetes, thyrotoxicosis
Deficiency diseases
Toxemia of pregnancy
Mother's age over 40 years
Primiparity
Uterine: tetany, contraction ring, or hemorrhage

Fetal Causes

Prematurity or immaturity
Fetal disease or congenital debility
Congenital anomalies, for example, defects of respiratory or circulatory system
Diaphragmatic hernia
Congenital diseases, for example, syphilis, erythroblastosis
Presentation and position (breech, transverse, or occiput posterior)
Placental abnormalities: gross infarction, low insertion placenta previa, or premature separation.
Cord abnormalities: prolapse, shortness; kinking or knotting; compression or torsion; or rupture of velamentous insertion

Obstetric Causes

Use of pituitrin or quinine
Prolonged and difficult labor
Delivery by version and extraction, breech extraction, mid-forceps, or cesarean section

Analgesic and Anesthetic Causes

Morphine, demerol®, paraldehyde, barbiturates
General anesthesia
Regional anesthesia when complicated by drop in maternal blood pressure caused by sympathetic paralysis or toxic reaction to the drug

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**Reprinted by permission of Dr. D. M. Little, Jr., Dr. R. M. Tovell, and the *New York State Journal of Medicine*.

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Careful and adequate prenatal care should not only prepare the mother for the ordeal of labor and delivery, but also should aim to produce a healthy, full term infant. Early recognition and prompt treatment of metabolic diseases, toxemias of pregnancy, and other maternal complications which may interfere with adequate nutrition and adequate oxygen supply to the growing fetus, cannot be too strongly emphasized. The prevention of prematurity alone would reduce neonatal mortality to a minimum. Simpson and Geppert[3] stress this factor of prevention of prematurity. They state that if the obstetrician is able to prolong pregnancy after the twenty-eighth week, he has increased by 25 percent to 50 percent the infant's chances for survival. "Since the fatality rates vary from 89.2 percent for infants born alive under 1,000 Gm. to 0.47 percent for full term infants born alive, it is obvious that the prevention of prematurity is the key to the reduction of this huge fetal loss."

In patients under observation and treatment for preeclampsia, nephritis, and hypertension, the obstetrician must decide when labor should be induced for the best interests of the mother, keeping in mind the risks of prematurity to the infant. The effects of preeclampsia that are toxic to the infant, and the inadequate nutrition in cases of nephritis, with multiple infarcts in the placenta, must be taken into consideration. Are the chances better for the baby with intrauterine or extrauterine life?

The physiologic action of the contracting uterus in maintaining adequate blood flow through the cord and keeping a constant fetal blood pressure is another important basic principle in the prevention of asphyxia. The contraction of the uterus is similar to the systolic phase of the heart action, forcing the blood out of the placenta through the umbilical veins; and relaxation of the uterus permits a diastolic phase in placental filling. A uterus in a constant state of contraction, as in tetany, or a relaxed uterus, as in inertia, will produce anoxia. The injudicious use of oxytocic drugs to induce labor or to stimulate uterine action in cases of uterine inertia should be avoided. In most hospitals there is a definite ruling concerning the use of pituitrin® or pitocin® for the induction of labor or for the stimulation of poor uterine contractions, and consultation with a specialist is required before giving a "pit-drip." The following method of administration has been found to be safe:[4]

Indications

1. Uterine inertia (primary). No mechanical obstruction.
2. Premature ruptured membranes with a ripe cervix, at term, and failure of medical induction.

Contraindications

1. Breech
2. Any abnormal presentation
3. Twins
4. Extra large baby
5. Para IV or over
6. Patient over 35 years of age
7. Fetal distress
8. Floating head

Procedure to be followed in induction of labor with pituitary infusion

1. The junior or senior attending physician must remain in the hospital during the entire induction.
2. In private cases, only physicians who have major obstetric privileges may do this procedure without consultation.
3. The resident on obstetrics must be notified and must be present on the floor when the procedure is started.
4. An intravenous infusion of 500 cc. saline (5 percent glucose in water, or normal saline solution) is to be started at a rate of 30 drops a minute or less. When the drip has been properly regulated, ½ cc. or 5 units of pitocin is added to the solution. An attendant is at the bedside at all times to record the fetal heart sounds, type and length of contractions, maternal pulse, and blood pressure. If labor is instituted, the induction may be continued in the labor room or discontinued at the discretion of the attending physician. If it is continued during labor, the patient is to be taken to the delivery room with the intravenous still running until the completion of the third stage of labor. If labor is not induced, the infusion is not to be repeated for an interval of 24 hours.
5. Procedure for treating tetany of the uterus. Stop the drip, administer 5 minims of adrenalin® intramuscularly. If the contraction continues, an anesthesia of either vinethene,® ether, or chloroform is to be given. Cyclopropane is not to be used. As soon as the tetanic contractions cease, oxygen should be administered to the mother by mask.

Induction of labor with intramuscular pitocin

1. Four hours following castor oil and an enema, the following is to be given: ¼ minim every 20 minutes for 2 doses, ½ minim every 20 minutes for 2 doses, and 1 minim every 20 minutes for 2 doses. The total dosage is not to exceed 6 doses, and the repeat dose of pitocin is not given if uterine contractions begin.
2. The same precautions regarding fetal and maternal observation are to be carried out as above.
3. The same treatment of tetanic contractions is used as above.

These precautions should avoid the danger of tetany or contraction ring. In certain cases of secondary uterine inertia, sedation, giving the patient a period of rest, may be advisable, and uterine contractions may resume a normal rhythm and force after such a rest period. These cases, usually occiput posterior positions, require the best obstetric judgment. Hoff[5] stresses the importance of maintaining a fetal blood pressure of between 75 to 100 mg. to provide adequate gas interchange. In severe, frequent contractions, the intrauterine pressure may reach 100 to 150 mg., causing anoxia, and in a relaxed uterus a sudden drop in pressure may actually cause a baby to "bleed to death in his own placenta."

Hemorrhage in the last trimester of pregnancy must be assumed to be from placenta previa, abruptio placenta, or occasionally from rupture of the uterus, until proven otherwise. Prompt diagnosis with the aid of soft tissue roentgenogram, early hospitalization, and prompt treatment are the important factors in producing a live baby and safeguarding the mother. Unless the patient is a multipara, with 5.0 to 6.0 cm. dilatation of the cervix, the usual procedure of choice in these cases is a cesarean section.

Careful administration of analgesic drugs during labor is important in the prevention of asphyxia neonatorum. Since the Read method has become popular with patients, less sedation has been found to be necessary. Demerol, 50 to 100 mg., with or without scopolamine, may be used with relative safety in a primigravida 2.0 to 3.0 cm. dilated. If the first stage of labor appears to be progressing rapidly, 40 mg. of nisentil® may be used with greater safety. We have found that nisentil appears to have little if any effect in depressing the respiratory center of the baby. When a premature baby is anticipated, no sedation should be given to the mother. Self-administered trilene® has become popular during the first and second stage of labor, and, combined with pudendal block in the second stage, has proved safe for both the mother and child. The present trend in most obstetric clinics of using less sedation during the first stage of labor, and more frequent employment of regional anesthesia in the second stage, is undoubtedly a wise procedure to decrease the incidence of anoxia and atelectasis[6] (Table IV).

During labor, the two chief signs of fetal distress are the passage of meconium stained amniotic fluid and a slowing of the fetal heart rate. While the presence of meconium in the amniotic fluid signifies some anoxia in a cephalic presentation, a definite bradycardia with a drop of 20 points in fetal heart rate is of greater significance. Checking the fetal heart every half hour during the first stage, and every five to ten minutes during the second stage, should be a routine procedure. If an irregularity of fetal heart rate, or a bradycardia, is present, the cause must be sought. One must always be alerted to the possibility of a prolapse of the cord.

TABLE IV.[7] INFANT DEATHS BY CAUSE AND TYPE OF ANESTHESIA†

Type of Anesthesia	Infections	Injuries at Birth	Anoxia	Abnormal Pulmonary Ventilation	All Causes
None	37.8	31.6	28.3	40.4	34.5
Inhalation	52.9	60.4	64.1	50.8	57.3
Local	6.5	5.1	5.2	5.4	5.7
Analgesics	2.8	2.9	2.4	3.4	2.5
Total	100.0	100.0	100.0	100.0	100.0

Whenever the membranes rupture and the presenting part is not fitting well into the pelvis, a careful vaginal examination should be done. A prolapsed cord is seldom diagnosed by rectal examination. Management of the case will depend largely upon the degree of prolapsus and the amount of cervical dilatation. The important point is to deliver the baby immediately, before a long period of anoxia develops, meanwhile administering oxygen to the mother and holding the cord up above the zone of compression.

Excessive activity of the baby during labor may signify a hypoglycemic state. Administration of 5 percent or 10 percent glucose intravenously to the mother may remedy this situation.

The prophylactic use of outlet forceps in primigravida and the slow delivery of the head with use of the modified Ritgen's maneuver are well accepted techniques which help to reduce the incidence of tentorial tears and cerebral hemorrhage. Administration of vitamin K to the mother every six hours during labor, and to the infant immediately after birth, decreases the incidence and extent of cerebral hemorrhage.[6] Some authorities doubt the value of this procedure in prevention of hemorrhagic disease of the newborn, but state it raises the prothrombin level of the infant.[6]

As soon as the head is delivered, care must be taken to wipe off the face and clear the air passages of mucus, blood, and amniotic fluid. In most cases, the immediate use of a tracheal catheter is sufficient to clear the upper respiratory tract. This should be done as soon as the baby is born, and preferably before it has time to take its first breath. The technique approved by the Chicago Health Department is as follows:[6]

†Reprinted by permission of Dr. H. N. Bundesen.

"The baby should be placed on its back with its head back and extended. The index finger is now run over the tongue and epiglottis, coming to rest on the arytenoid cartilages. The latter may be felt as two firm edges about one-fourth inch apart. The catheter of woven material, size 14 or 15 French for a full term baby, or size 10 or 11 for a premature infant, is gently passed under the index finger until the tip lies behind the epiglottis and over the rim. The index finger further directs the catheter into the trachea by bending the catheter slightly forward as it is introduced. Care should be taken to avoid injuring the delicate mucous membrane. With the catheter well in the trachea, gentle suction through a glass bulb is applied to the outer end. The bulb is emptied and the suction continued until the trachea is clear of obstruction."

If a general anesthetic is being administered, instructions should be given to the anesthetist to give straight oxygen to the mother as the baby is being born. Delay in clamping of the cord, with stripping of the cord toward the baby, gives the baby an extra amount of blood which is stored in the placenta. This has been proved by studies of hemoglobin content and red blood counts of the newborn infants. After the cord has ceased pulsating and has been stripped, it should be doubly clamped four or five inches away from the skin insertion, and cut between the clamps. As soon as the cord has been cut, the baby is placed on its right side in a preheated bassinet and kept warm. Further clearing of the air passages is important and often necessary before any artificial resuscitation should be used. Administration of oxygen is of no avail unless the baby is breathing. Some of you may be old enough to remember the time when two basins, one of hot water and one of cold water, were kept in readiness for immersion of the infant, to stimulate respirations, as well as the custom of hanging the baby upside down and stroking the mucus from the trachea. We now realize that sometimes more harm than good may have been done by these procedures.

The first and most important thing is to see that the baby is breathing properly. Modern hospitals are now equipped with some type of mechanical resuscitator. These apparatuses are of value only when the obstetric staff is familiar with their use, and when the apparatus is checked at regular intervals so that it is kept in working order. The obstetric resident or intern should also be familiar with the use of the infant laryngoscope. His first day on duty, he should be instructed carefully in the use of the laryngoscope and the resuscitator apparatus. There are two types of resuscitators in general use at the present time, the Emerson or E & J resuscitator, with an alternating positive pressure of 13 mm. mercury to a negative pressure of 9 mm. of mercury, and the Kreiselman resuscitator, with intermittent positive pressure (12 mm. Hg. the upper limit).[2] At the Woman's Medical College Hospital, we have found the Kreiselman resuscitator better. It has the advantage of an attached suction apparatus, and we feel that the intermittent positive pressure induces a more natural type of respiratory movement in the infant. The rate of oxygen flow recommended is 6 liters per minute.[2]

Bloxsom[7] has advocated the use of the positive pressure oxygen air lock apparatus. One of the points he stresses is that by this means considerable oxygen is absorbed through the skin and mucous membranes of the upper respiratory passages, and traumatic use of the tracheal catheter and laryngoscope can be avoided. In spite of the excellent results obtained by Bloxsom and his co-workers, this expensive machine has not become generally popular.

Warmth is another important factor immediately after birth. Premature babies especially must be kept warm while being resuscitated, and the bassinet must be pre-heated. They must also be kept warm in transportation from the delivery room or operating room to the nursery.

In cases of asphyxia of the newborn, it used to be customary to give alpha-lobelin or coramine as a respiratory stimulant, and occasionally injections of adrenalin were given into the heart. The studies of various neonatal committees have proved that these drugs are of little value, and the danger involved in their use is great because of their toxic effects. Instead, the other methods outlined have proved to give better results.

After breathing has been well established, the next most important item is the care of the eyes. The Credé prophylactic treatment of the eyes of the newborn is still regulated by the state law in Pennsylvania. One drop of one percent solution of silver nitrate is placed in each eye. Whether the eyes are flushed with saline solution before and after the use of the silver nitrate is an optional matter. Some clinics have changed to using penicillin drops as prophylactic treatment for the eyes, but this method has not been generally accepted so far in Pennsylvania. It is important to instill the eye drops as soon as possible, as pseudomonas infection and gonorrheal ophthalmitis are still known to occur in the newborn infant. It is the duty of the obstetrician to instruct the nurse, medical student or intern carefully in the proper method of instillation of these eye drops to avoid any trauma.

The cord may then be tied and wiped with alcohol or zephiran® chloride and a sterile dressing applied. If the infant is in poor condition, the tying of the cord may be delayed until the baby is placed in the Isolette®. The use of the cord clamp is popular with some obstetricians, as it is felt it reduces the chance of bleeding from the cord, especially when the cord contains a large amount of Wharton's jelly. These clamps are inexpensive.

Proper identification of the infant is an important procedure before the baby leaves the delivery room. It is also important to remember this when a cesarean section may be done in the operating room. A footprint of the infant and the thumb print of the mother are taken, and the baby is tagged with a bead bracelet, anklet, or some other means which is secure. It is also important to have additional identification in cases of common names. In the case of multiple births, letters or numerals are used to designate the order of birth, as this might become a legal question.

The problem of proper care and resuscitation of babies born by cesarean section is sometimes neglected. A heated crib should be available for use in the operating room, if it is the custom to do cesarean sections there. The same equipment: resuscitator, laryngoscope, and so forth, should be readily available. A baby born through an abdominal incision is more likely to aspirate blood and amniotic fluid and does not have the advantage of having this material expelled from its air passages by the process of birth. The suction apparatus may be used to advantage as the baby's face is being delivered through the incision. It is well known that the neonatal mortality rate for infants delivered by cesarean section is considerably higher (34.7 per thousand) than for spontaneous deliveries (20 per thousand).[6] This is partly owing to the fact that the cesarean may be done because of some serious obstetric emergency. Therefore, these babies are already partially anoxic and need the most skillful resuscitation. Recent statistics show that the likelihood of hyaline membrane formation is more frequent in babies born by cesarean section than by the vaginal route.

If a baby is born with a heartbeat, it is considered a live birth, whether or not it shows any signs of breathing. A stillborn baby is one that shows no signs of breathing or gasping and has no heartbeat. Actually, a viable baby now in Pennsylvania is one of 16 weeks' gestation.

In Rh negative patients, the usual procedure is as follows: At the time of the patient's first visit to the office or clinic, blood is drawn for Rh factor, Kolmer and Kline, hemoglobin, and typing. If the patient is Rh negative, the Rh factor of the husband should be determined. If the husband is Rh negative, no further Rh studies are done on the patient. If the patient is Rh negative, a primigravida with no history of blood transfusions or miscarriages, and the husband is Rh positive, blood should be drawn for Rh sensitivity test at the seventh month. From then on to term, repeat tests should be taken every three weeks. In multigravidas, the procedure is much the same, but sensitivity tests should be taken earlier and more frequently. A few years ago, in patients with a rising antibody titer, labor was induced prematurely. Most authorities now agree that the risks of prematurity are greater for the infant than the risks of Rh sensitivity. Therefore, labor is seldom induced in these patients before the thirty-eighth week. A rising antibody titer, however, alerts the obstetrician to have the team of pediatricians present at the time of birth to give an immediate exchange transfusion to the infant. At the time of delivery, cord blood is taken and examined for Rh factor, Coombs' test, hemoglobin and RBC, and smear for erythroblasts. If the Coombs' test is positive, an exchange transfusion is given, using the umbilical vein of the infant. The cord is clamped immediately at birth, but is not tied until the laboratory report has been obtained. The time element in performing exchange transfusions may be the deciding factor in the life of the baby, and every hospital should have on 24 hour call a team of pediatricians trained in the technic of exchange transfusions.

Prompt recognition of cerebral hemorrhage is also of great importance, and early consultation with a pediatrician is necessary.

The relationship between the obstetrician and the pediatrician is important, and it is only fair to inform the pediatrician immediately if the newborn baby is not in good condition.

Postmaturity is also a problem which confronts the obstetrician, and it is difficult to diagnose accurately. The postmature placenta may interfere with adequate oxygenation of the blood. The added difficulty of delivery of a large baby with possible impaction of the shoulders increases the danger of premature respiratory movements and aspiration of large quantities of amniotic fluid. After delivery, these babies require the same careful regulation of oxygen and humidity as the premature babies.

Before the baby leaves the delivery room, a complete physical examination should be done and the following points especially noted:

1. Color of the infant, including general color and the extremities

2. Type of cry

3. Amount of rib retraction

4. Aeration of the lungs

5. Any gross abnormalities, such as polydactylism, hypospadias, and so forth. It is well to inform the father immediately of any abnormalities noted at the time of birth.

The final duty is to see that the pediatrician or pediatric resident in charge of the nursery has been informed of the condition of this newborn infant. Once in the nursery, the baby is transferred to the care of the pediatrician.

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CASE REPORT

Acute Intermittent Porphyria*

Gertrude LaBotz Crum, M.D.

THIS IS A REPORT of a patient with acute intermittent porphyria who was on the pediatric ward of Philadelphia General Hospital. Since we are not accustomed to think of acute intermittent porphyria as occurring in children, this case is reported to suggest consideration of this diagnosis in children who have behavior problems and vague pains.

Case Report

The patient, Negro male, aged 12 years, was admitted to our hospital November 8, 1954, with the chief complaint of "pain in the stomach and weakness."

Past history. Normal birth and development. Pertussis during infancy.

In 1946, at the age of 4 years, he was circumcised. At this time it was noted that he had bilateral inguinal hernias. After that time, his mother watched him carefully, frequently calling him from play to reduce the hernias.

In 1950, at 8 years of age, the patient had bilateral inguinal herniorrhaphies. His mother stated that he has always been clumsy and frequently gets hurt at play. At time of discharge, his mother was told that the patient should not participate in strenuous activities. Since that time she has been overprotective, not allowing the boy to play outdoors with other children, and walking to and from school with him.

Dr. Crum is Senior Resident in Pediatrics, Philadelphia General Hospital, Philadelphia.

About October 25, 1954, this patient began to have abdominal pain. He was admitted to the hospital October 27 with possible appendicitis. At that time he had nausea, but he did not vomit. The abdominal pain was sharp and intermittent. The pain began in the epigastrium, shifted to the flanks, and then radiated downward and inward toward the scrotum. There was no change in bowel habits. On physical examination, the abdomen was found to be soft, although tenderness was present in both lower quadrants. At this time, the patient also had a temperature of 102 F. (oral), follicular tonsillitis, and a grade II apical systolic cardiac murmur.

Laboratory studies showed a hemoglobin of 11.3 Gm., a white blood count of 22,000 with 85 percent neutrophils, 11 percent lymphocytes, and 4 percent monocytes. The urinalysis was normal except for 10 to 15 white blood cells per high power field. Chest and abdominal roentgenograms were normal.

The diagnosis was acute tonsillitis. The patient was treated with penicillin and streptomycin. Decrease of temperature and improvement in clinical condition followed. The nurses noted that he moved with abnormal slowness. Five days after admission, the boy was discharged.

On the patient's last admission to the hospital on November 8, 1954, the following history was presented by his mother. She was emotionally disturbed, cried continuously during the interview, and gave evasive answers to questions.

*Dr. Paul Gyorgy granted permission to publish this case from his service at Philadelphia General Hospital, and Dr. George Ludwig, University of Pennsylvania, made the quantitative porphyrin determinations.

Since the patient's previous hospitalization, the boy complained less of abdominal pain, but he had not returned to school. He became progressively weaker. The day before admission, the abdominal pain again became severe. There was no change in appetite or bowel habits.

On the day of admission, the patient came to the clinic in a wheel chair. He was unable to move because of severe pain in the abdomen and legs. He was admitted to the pediatric ward with possible conversion hysteria.

Social history. The patient's father and mother are separated. The boy lives with his mother, maternal grandmother, and three siblings in a three bedroom house. His mother does domestic work to support the household. The patient had to repeat the sixth grade in school and dislikes his sister for attaining the same academic level. There is no known familial history of porphyria.

Physical examination. Temperature of 101.6 F., blood pressure was 100/55 mm. of mercury, with a pulse rate of 108. Weight was 65 pounds.

The patient displayed marked slowness of motion which he said was caused by pain in the abdomen, thighs, and knees. The slow motion appeared exaggerated and out of proportion to the pain, of which he complained little. For example, the patient would move his arm very slowly when he had abdominal pain. There appeared to be generalized weakness.

Examination of the eyes revealed bilateral congenital cataracts. Ears and nose were normal. The pharynx was slightly injected. The lungs were clear on auscultation and percussion. There was a soft systolic murmur heard best over the pulmonic area, and a tachycardia was present. On abdominal examination, there was shifting tenderness to deep palpation. The abdomen was soft; no evidence of muscle guarding. Right costovertebral angle tenderness was definite on the first examination, but in later ones this was not marked. The extremities showed no bone tenderness. There was no redness, swelling, or tenderness of the joints, but patient complained of pain on motion of the knees. Peripheral pulses were palpable. Neurologic examination was normal except for minimal generalized muscular weakness. There were no skin lesions or scars.

Course in the hospital. For approximately one and a half weeks after admission there was no change in the patient's clinical picture. He continued to move slowly and often moaned and groaned. Occasionally, when he was not aware that he was noticed, he would move faster. He took frequent naps during the day. At first his sleep was interrupted during the night because of pain. Before the spinal tap procedure, he was frightened, but he did not move when the tap was done and afterward stated that he did not feel the needle. However, pinprick sensation was intact in the lumbar area, as elsewhere.

Two days after admission, the nurse noted that his urine was red when she was discarding it. Unfortunately, none was saved. Subsequent specimens were colorless. Four hours of late afternoon sun failed to change the urine color. On November 12, three specimens showed positive Watson-Schwartz tests. Later specimens were negative.

The patient gradually improved. Temperature which was fairly constant at 101 F. for the first week after admission, gradually decreased to normal. He also had better motion and less pain. On November 23, one grain of phenobarbital was given to try to precipitate an attack. There was no effect. The following day, 1½ grains were given three times a day. This also was without results. On November 30, when he was discharged from the hospital (22 days after admission), the boy was able to move normally and had no pain.

Therapy in the hospital. Procaine penicillin (300,000 units twice a day) was started on the day of admission. Because there was no clinical response, on November 13, (five days later), the antibiotic was changed to tetracycline (200 mg. every six hours).

Laboratory studies (Tables I, II, III, and IV):

TABLE I. BLOOD COUNT

	Nov. 9, 1954	Nov. 12	Nov. 15	Nov. 19
Hemoglobin	10.5 Gm.	10 Gm.	9.9 Gm.	9.8 Gm.
WBC	29,000	16,600	15,600	13,800
Neutro.	86%	88%	70%	
Lymph.	2%	7%	19%	
Mono.	12%	4%	6%	
Eosin.		1%	5%	
Reticulocytes	0.4%			

TABLE II. URINE

	Nov. 9, 1954	Nov. 11
Color	straw	yellow
Reaction	acid	acid
Specific gravity	1.026	1.020
Protein	1 plus	trace
Sugar	0	0
Acetone	0	trace
WBC (per high power field)	10-20	1-4
RBC (per high power field)	occasional	8-10
Casts	1-4	0

TABLE III. CEREBRAL SPINAL FLUID

	Nov. 10, 1954	Nov. 19
WBC	5	2
RBC	0	2
Sugar (mg. %)	86	—
Chloride (mg. %)	714	—
Protein (mg. %)	16	17
Culture	No growth	
Colloidal gold	1,221,000,000	

TABLE IV. WATSON-SCHWARTZ TEST

Date	Result	Date	Result
Nov. 12	plus	Nov. 22	0
Nov. 12	plus	Nov. 23	0
Nov. 12	plus	Nov. 24	0
Nov. 12	0	Nov. 24	0
Nov. 15	0	Nov. 24	0
Nov. 18	0	Nov. 25	0
Nov. 20	0	Nov. 26	0

Serum protein 6.4 Gm. (albumin 3.4 Gm., globulin 3.0 Gm.), serum cholesterol 73 mg. percent (esters 31 mg. percent), blood urea nitrogen 12 mg. percent, serum sodium 128 mEq/liter, serum potassium 4.5 mEq./liter; serologic test was positive (8 Kahn units). Bromsulphalein excretion test showed 1 percent retention. Cephalin flocculation was reported as 1 plus. Thymol flocculation was negative; thymol turbidity reaction was 2.5 units. The thymol turbidity test was repeated a few days later; reaction was 4.8 units.

The erythrocyte sedimentation rate was 110 (normal 0-22). The antihyaluronidase titer was 1:768 and the antistreptolysin titer was 1:256. Heterophile titer was

1:14. Studies for cold and febrile agglutinins were negative. PPD tuberculin test (first and second strength) had a negative reaction.

There was no growth on cultures of blood and urine. Nasopharyngeal and throat cultures grew out normal flora. On November 18, after Watson-Schwartz tests had become negative, the urine failed to show the presence of porphyrins on spectroscopic examination.

Follow-up visits in clinic. Two weeks and one month, after discharge, the patient was in good condition, able to carry on normal activity. He had no recurrences of weakness and pains. Two months after discharge, when the patient was asymptomatic, quantitative porphyrin studies were done of the urine. There was no porphobilinogen present. Coproporphyrin was reported as 334 micrograms per 24 hour sample of urine. (Top normal is 300 micrograms.)

Discussion

According to the literature, acute intermittent porphyria presents a triad of symptoms: 1) abdominal pain 2) peripheral neuropathy or weakness, and 3) mental or psychic changes.

This patient had abdominal pain and, characteristically, the abdomen was soft on examination. He also had pain in the legs and other vague pains which often occur in porphyria.

Most patients with this type of porphyria have a history of having had one or more abdominal operations performed either to make a diagnosis or because of a mistaken one. This patient had had a previous admission for appendicitis, but operation was postponed because physical examination of the abdomen did not suggest an abdominal condition or disease.

The only evidence of peripheral neuropathy that this patient presented was generalized weakness, without definite onset or progression. His weakness, however, at times did appear to be functional. The consulting neurologist agreed that a certain degree of weakness was present.

The psychic change was the major symptom of this patient. Because of his affected manner, he was admitted as a case of conversion hysteria. His history shows great psychologic disturbance. It was felt that the patient's mother was instrumental in the development of his behavior and neurotic episode; however, psychic manifestations are now thought to be part of the picture seen in acute intermittent porphyria.

Of minor consideration, this patient also had a low grade fever (up to 101 F.) during his acute episode. As the child's condition improved, his temperature gradually became normal.

This patient failed to have an attack after he was given barbiturates. Although they are known to precipitate attacks in some cases, some patients have failed to respond and others have recovered while taking barbiturates.[1]

The only laboratory study that verified the diagnosis of porphyria was a Watson-Schwartz test, positive on three samples taken on one day. Subsequent specimens were negative. A positive Watson-Schwartz test for the presence of porphobilinogen is pathognomonic of porphyria.[2] Spectroscopic examination for the presence of coproporphyrin, uroporphyrin, and porphobilinogen was negative. This test was done after there was clinical improvement and Watson-Schwartz tests were negative. The significance of the slight elevation of the urine coproporphyrins cannot be evaluated at this time.

According to Kark,[3] this disease may occur at 10 years of age; however, the peak incidence of onset is in the third decade. This case illustrates the early onset of the disease.

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Woman's Opportunity for Service

A MID-CENTURY LOOK

Dorothy D. Houghton, Litt.D., LL.D.

A MID-CENTURY LOOK AT WOMAN'S ROLE could best be taken in three parts: the past when woman's opportunity was created, the present in which we might well say the dream has materialized, and the future with its ever growing challenge.

When we are speaking of the past, the names of many great American women come to our minds; pioneers remembered and revered by us all, women who took up the cause, not only of equal political rights, but also of higher education for women. First, of course, we think of the woman of whom it was said that she changed the mind of a nation: Susan B. Anthony, the suffrage-pioneer who now belongs to the history makers of our Republic and stands as the symbol of women's emancipation.

It was this very spirit which also filled the heart of Elizabeth Blackwell, the first woman in the United States to study and graduate from an approved medical school. The times when she was the nine day wonder in Geneva seem far away indeed. The young women enrolled in the Woman's Medical College of Pennsylvania today need no longer fear to be followed by little boys in the street, shouting improvised rhymes like, "Doctor! Doctor in petticoats! Do you cure corns? Or do you cure colds?" Students today are sending home proud letters, and it must be hard for them to imagine that Elizabeth Blackwell had to seek consolation in sharing her experiences with her sister, Marion, when she wrote, "I had evidently so shocked Geneva propriety that the theory was established at once that either I was a bad woman, whose designs would gradually become evident, or that, being insane, an outbreak of insanity would soon be apparent."[1]

When Elizabeth sought a room in local boardinghouses, the landladies shut the doors in her face, claiming that they ran "a correct house." When she was finally accepted by a Scotswoman, Miss Waller by name, she was forewarned not to expect any civility from the other guests. And she got little. She also was deeply puzzled and depressed by the reception at Geneva College where the registrar made it quite clear that she had shown a great breach of taste in presenting herself. But her indomitable spirit won. As she had promised the dean upon receipt of her degree in 1849, her entire life was one relentless effort to shed honor on this medical diploma.

Women in medicine have made good. They have fulfilled the hopes and adhered to the dictate voiced by Ann Preston in her address to the class of 1858, in which she said: "Your business is not to war with words, but to 'make good' your position upon the bodies of your patients by deeds of healing."

Our words of profound respect and gratitude toward these great women of the past are praiseworthy tributes indeed. But though they are fitting and richly deserved, they connote a rather passive appreciation. Today, in the year of 1954, the quintessential achievement in women's emancipation is the equal responsibility we can now share with the men of our country. We might say the equal rights we share with our men; but we so readily, all too easily, remember our rights! And how often, while remembering and claiming them, we do not make use of them at all. But if we do take full advantage of our equal rights as voting citizens, and of the vast opportunities in the professions, the local, state, and federal governments as we should, then we do have an equal hand in shaping our destiny. And it is for this reason that equal responsibility is important. Let us be sure that the women of America are giving their level best to keep our country free, prosperous, and great.

It is well to stress how important it is that we stop considering ourselves as a separate entity, and realize that we are an integral part of our nation at work, to be judged alongside of men, because of merit and comparable qualification, not with a special yardstick for members of the female sex. The headlines should read: "Mrs. Brown was appointed District Judge" rather than: "Judgeship Goes to Woman." We should make our mark in the world through our contribution, and not encourage others to tinge their appraisal of us because of the fact that we are females. In 1851, Dr. Joseph Longshore

Mrs. Houghton is Assistant Director, Foreign Operations Administration, where she is Director, Office for Refugees, Migration and Voluntary Assistance. *This speech was delivered before the Woman's Medical College of Pennsylvania on June 9, 1954.*

said in his valedictory address to the first class: "Forget you are women. . . . Remember you are physicians." This advice should be heeded by all women, in all professions, everywhere.

With the renewed emphasis President Eisenhower has placed upon choosing women for public office, the opportunities for women to apply themselves in the service of their country is steadily growing. There is not a single facet in our daily life and that of our nation, in which women cannot voice their opinions and take an active part in charting the many important courses of action which build our future.

We have arrived at the third step in our look at the challenge for women, namely, our role in the future, a future which is an ever growing challenge, both at home and abroad.

Secretary Oveta Culp Hobby, head of the Department of Health, Education, and Welfare, in her recent address before the new New York Infirmary, paid tribute to the role women are playing in her department, both in science and in medicine. She also mentioned six points of need in the field of health today: 1) more aggressive and imaginative research into the causes and treatment of disease, 2) broader and better protection against the costs of illness, 3) the need for additional hospital beds, especially for chronically ill, and for greater outpatient services, 4) better facilities for rehabilitation of the disabled, 5) better measures for the prevention of disease, and 6) improvement of services for child health and welfare.

A matter of great concern is the acute shortage of trained personnel in the health professions. Among our city, county, state, and federal health departments, there exist annually over 2,000 unfilled professional positions. When we consider that every day 11,000 babies are born in America, that each month 330,000 human beings are thus added to our population, shortage of manpower in the health professions does give us reason for concern.

On a nation-wide basis it is estimated that 300,000 physicians will be needed by 1960, as compared with 201,300 physicians who were registered with the American Medical Association in 1952. There are scarcely 1,000 trained speech therapists in the country at the present time, which means about one speech therapist to every 152,000 persons in the population. This limited number does not begin to meet the need, and over 20,000 additional speech therapists are needed at this time. The demand for occcupational therapists, a profession almost entirely filled by women, far exceeds the supply, and the present shortage amounts to more than 6,000. The shortage in nurse anesthetists is acute. In the field of professional and practical nursing the need is tremendous. It is anticipated that 65,000 additional professional nurses will be needed by 1960. These facts illustrate but a fraction of the many existing needs, but they do serve our purpose of high-lighting the challenge we will have to face.

Let us look beyond our national borderline, at the world at large. In the Foreign Operations Administration, one has a firsthand opportunity to study and to look at the needs of the world, especially those in underdeveloped areas which make up a large part of it, and the impact of these needs upon our foreign policy operations. The Foreign Operations Administration carries out its work under the able leadership of Harold E. Stassen and the foreign policy guidance of our Secretary of State, John Foster Dulles. The Office for Refugees, Migration and Voluntary Assistance is concerned with the fate of 35 million refugees who are trying to survive in the world today. You can find them scattered throughout many countries between the Iron and the Bamboo Curtain, from Korea, clear across the globe to Germany. Mr. Stassen, by selecting a woman as director, was emphasizing the importance of viewing the refugee problem not just from the point of view of the technician and the expert, but with a mother's heart as well, one that could appreciate the importance of extending a helping hand to ease the pain and the loneliness that goes with being a refugee.

In addition to projects of assistance, maintenance, and resettlement for refugees, there is an FOA program in which physicians will have particular interest: namely, that of technical co-operation and community development in underdeveloped areas of the world. Mr. Stassen[2] remarked in his recent address to the Ministerial Union that "these programs are more than a reflection of the highest American humanitarianism; their concept springs from the moral and ethical obligations of man to his fellowmen, which are the strength and foundation of our Christian tradition."

FOA's public health personnel today work in 38 countries of Asia, Africa, the Near East, and Latin America. Upon the request of the various host governments, 366 U. S. technicians in the field of health were sent overseas to work in programs of technical co-operation. But here again, the demand for trained personnel far outweighs the number of those physicians, nurses, and technicians who show a willingness to go to these faraway lands.

To give an accurate picture of FOA's personnel needs in the health professions, the 120 established positions in our Health Division are:

10 positions for Laboratory Technicians

15 positions for Health Educators
5 positions for Medical Social Workers
5 positions for Nutritionists
5 positions for Maternal and Child Health Physicians (This is but an initial estimate which will increase rapidly.)
75 positions for Public Health Nurses
5 positions for Vital Statisticians

At present many of these positions are vacant.

The sacrifices this work entails are many. The public health nurse, for instance, will frequently be found riding for many hours in an open jeep, over bumpy, dusty roads, to remote villages out of reach of the established health center. Yet, the world is in desperate need of these women whose missionary spirit will help lift the load off the back of suffering mankind.

To illustrate the magnitude of this challenge, let us consider the following facts. In the United States, life expectancy is almost 70 years, and our 15 year old children in junior high schools can look forward to more than another half century of work and play. In the underdeveloped areas, however, if a child reaches 15, he has reached middle age.

What is it we have to offer to countries such as Iran where 50 percent of all babies born will die before they are one year old; to a country like Egypt where three out of five children born will die before their sixth birthday; and to India, where life expectancy at birth is 27 years, where many a midwife still wipes her hands with earth before attending to the woman in labor?

What we have to offer, Dr. H. van Zile Hyde, a medical director in the U. S. Public Health Service, once said, is nothing miraculous or abstruse. "It would seem to me," he said, "based on our own accomplishment and not on conceit that we have to offer: an appreciation of the environment as a basis of ill health; a willingness to tackle the simple and obvious and even the disgusting; a certain knack in planning and organizing; a boldness that has made America American; and a faith in every man, his importance, and his ability to do for himself." He concluded by saying that what is needed in Indo-China, in Thailand, India, Pakistan, Iraq, and other friendly nations who would like to share with us our experience and technical know-how, "is the local health officer, the division director or his assistant, the sanitary engineer, sanitarian, the public health nurse, the nurse educator, the health educator, who know how to tackle problems simply, decisively, and finally. We need them from Massachusetts, from Pennsylvania, from California, from America, to work in far parts for the free world" (By permission of Dr. Hyde).

Women physicians in FOA have been doing outstanding work, and are doing it at this very moment. Dr. Estella Ford Warner, our public health chief in the U. S. Technical Cooperation Mission of FOA/India, is now past 60, but she has recently returned to that country. She glows with enthusiasm when she speaks about the future programs concerned with the improvement and purification of the water supply for India's 700,000 rural villages; the programs for malaria control; the establishment of dispensaries, clinics, and hospitals; and the training of Indian doctors, nurses, and midwives. Prior to her appointment in India, she spent nine months in Beirut, Lebanon, as adviser to the Ministry of Health. Simultaneously, she assisted the American University of Beirut in reorganizing its outpatient clinic. At the conclusion of her service there, the Lebanese government awarded her the "Cross of Lebanon for Distinguished Service." This was a rewarding tribute to Dr. Warner indeed, who had been the first woman technician in health and medical science ever to be sent to the Near East by the U.S. government, and the first woman health officer commissioned in the Public Health Service.

Dr. Carroll L. Birch, professor of medicine from the University of Illinois, is doing a splendid job in New Delhi, India. Dr. Birch is the first woman physician we have ever been invited to send to head a medical college. She has now been the dean of the Lady Hardinge Medical College for almost two years. This residential college is located in the heart of the city, has spacious, garden-like grounds, and its 60 acres are enclosed by a stone wall. Her job is a tremendous one! Not only does she teach and heal, but she also is in charge of everything and everybody connected with the School and the Hospital. She literally acts as the "Lord High Mayor" for 2,000 people, comprising the students, the patients, the professional staff, and the nurses. Even the more than four hundred servants and their many children, who also live within the compound, come to her with their problems.

Dr. Janet Mackie has left for Thailand, where she will head a public health training center which will give refresher training to physicians, sanitarians, nurses, and midwives. She says that very often medical women are able to perform tasks which male physicians would find difficult to do, because of local customs and cultures in countries where women lead their lives quite apart from men. She became aware of this fact while spending 12 years in Central and Southeast Africa. At one time she had been wondering for many months why the tribal women would not seek her assistance when excessive labor pains or other complications would prolong the process

of childbirth. The women seemed willing to die rather than call for her assistance, despite the fact that they showed great confidence when in need of other treatments. After having learned the local tongue, she chatted with several of the women and tried to solve this mystery. She finally discovered that it was based on an old established tribal belief which required women to deliver their babies in the shortest imaginable time. Everything was done to accelerate birth. The effects of certain herbs and roots, which were used for this purpose, were devastating and caused many deaths for both mother and child. Dr. Mackie then discovered that this practice was caused by the tribal assumption that any husband was considered guilty of grave moral slips if his wife was "cursed" with a prolonged or otherwise complicated delivery.

Dr. Mackie advocates the dispatching of teams into underdeveloped countries. She feels that in teams composed of physicians, nurses, and midwives, one enhances the contribution of the other. She claims that the nurses on an outpost can often carry on the work initiated and established by the physician and thereby save valuable time. As an example of this effective teamwork, she describes Dr. Betty Trevitt's group. Together with two nurses and midwives, Dr. Trevitt operates an FOA demonstration and training center for prenatal, delivery, and postnatal maternal and child care. They are located halfway between Baghdad and Basra in Iraq, and are greatly respected and appreciated by the Iraqi doctors for the outstanding work they are doing there.

Splendid work is done by the United States voluntary agencies and the missionaries all over the world. Technical missionaries were in the field for many years before foreign technical assistance became a national policy. It is Mr. Stassen's wish to stimulate and foster co-operative relationships between the voluntary agencies and FOA's programs. The lessons they learned, their methods, and the reputation they established will be of great help to FOA, while the FOA can assist the voluntary agencies by supporting their technical projects.

Whether we think of Sister Mary Benedict who, at the age of 35, is one of the five nun-surgeons in Asia, and is in charge of the 350 bed Holy Family Hospital in Dacca, Pakistan; or the Maryknoll Sisters in Korea; the medical teams of the Unitarian Service Committee; or the medical missionaries of the Seventh Day Adventists who work primarily in Africa and the Far East; all are making a most significant contribution with the help and voluntary support of the American public.

These then are a few high lights of the United States effort in meeting the challenge we face in the underdeveloped areas of the world. However, the vast multilateral effort put forth by the specialized agencies of the United Nations Organization has brought immeasurable improvement to thousands of communities in underdeveloped regions of the world.

The work of the World Health Organization is carried out through six regional offices, each serving a group of countries whose medical problems are similar. In Southeast Asia, where thousands of houseboats float on the sluggish waters of the canals, inhabited by an average of five persons, water-borne diseases are a prime cause of death. Here, as in so many other regions, the World Health Organization has fought typhoid, cholera, and other intestinal sicknesses. World Health Organization rural health nurses make arduous rounds in Lapland, often by ski and reindeer sledge, to visit patients.

By its constitution, WHO is dedicated to work for "the attainment by all peoples of the highest possible level of health." Today the organization, established as a permanent body on September 1, 1948, has a membership of over eighty countries in all parts of the world.

The United Nations Children's Fund is currently assisting programs in 69 countries mostly with long-range programs that will make a permanent improvement in conditions of maternal and child welfare. UNICEF aids and encourages solutions of problems that have afflicted generations of children in Africa, Asia, the Eastern Mediterranean area, Europe, and Latin America. To help countries initiate different mass health campaigns, UNICEF provides supplies such as insecticides, penicillin, vaccines, vehicles, and essential equipment not available locally. All medical assistance given by UNICEF is of a type approved by a joint UNICEF/WHO committee.

The United Nations Technical Assistance Program works hand-in-hand with the other specialized agencies in health programs, and each is contributing its share toward a gradual but steady amelioration of world health conditions.

While considering the UN effort in the realm of world health improvement, let us not overlook the charitable work carried on by the United Nations High Commissioner for Refugees. In addition to other tasks within his mandate, the High Commissioner assists hardship cases by finding institutions which will accept the aged and the sick who, because of their physical handicaps, may be barred from resettlement in other countries. He also aids refugee physicians, trying to place them in United Nations health programs.

These then are the works of peace that await our participation at home and abroad. These good works are the implementation of the concept President Eisenhower expressed a year ago, when he urged: "the dedication of the energies, the resources, and the imaginations of all peaceful nations to a new kind of war. This would be a declared total war, not upon any human enemy, but upon the brute forces of poverty and need." And he went on to say: ". . . The purposes of this great work would be to help other peoples to develop the underdeveloped areas of the world, to stimulate profitable and fair world trade, to assist all peoples to know the blessings of productive freedom. The monuments to this new kind of war would be these: roads and schools, hospitals and homes, food and health. We are ready, in short, to dedicate our strength to serving the needs, rather than the fears, of the world."

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[1]Baker, Rachel, The First Woman Doctor, the Story of Elizabeth Blackwell, M.D., New York, Julian Messner, Inc., 1950, pp. 68, 71.

[2]Authorized extracts from address by Harold E. Stassen before Ministerial Union of Washington, Central Union Mission, Washington, D.C., May 24, 1954.

ASSEMBLY OF WORLD BROTHERHOOD

You are invited to participate in the World Assembly of World Brotherhood at Brussels, Belgium, July 11 to 15 of this year. Ambassador Carlos P. Romulo and Minister Paul-Henri Spaak hope that you can join the 450 to 500 world leaders who will be taking part in these meetings. You have an important contribution to make to the subjects to be discussed and you would profit from joining in the discussions with leading men and women from Asia, Africa, Europe, and North America.

For further information write: Arthur H. Compton, General Chairman, World Brotherhood, 37 Quai Wilson, Geneva, Switzerland.

WOMAN'S MEDICAL COLLEGE COMMENCEMENT—1955

The Woman's Medical College of Pennsylvania extends a cordial invitation to all members of the American Medical Women's Association to attend the commencement exercises in the Irvine Auditorium at Thirty-Fourth and Spruce Streets, Philadelphia, on Friday, June 10, 1955, at 11:00 o'clock. Dr. William C. Menninger will be the commencement speaker.

AMWA members are also invited to visit the College when they are in the Philadelphia area. The "A" bus north from the center of the city goes directly to the College doorstep and provides an inexpensive way to get there.

ELIZABETH B. BROWN, M.D.

Guest Editor

We welcome Dr. Elizabeth B. Brown, Guest Editor of the Branch Twenty-Five, Philadelphia, issue of the JOURNAL. Dr. Brown is president of Branch Twenty-Five; is assistant professor of medicine, Hahnemann Medical College, Philadelphia; and attending physician at Hahnemann Hospital. She is chief of allergy at that hospital, and acting chief, pediatric allergy, Philadelphia General Hospital. She has served as instructor in bacteriology at Hahnemann Medical School and as bacteriologist, Sharp and Dohme Laboratories, Glenolden.

Dr. Brown is a yachting enthusiast and also relaxes by playing her piano. She is married to Dr. Leland Brown, a biochemist. She entered medical school after her family was complete and when her youngest child was five years of age.

OUT OF THE TURMOIL AND UPHEAVAL of the world today, it becomes increasingly evident that we must remodel our point of view; to think in terms beyond the local community, of the world at large. As physicians, our concern is with health on an international level. The following portions of articles show what is being done today to solve some of these most urgent problems. They are reprinted through the courtesy of the authors, and the *Journal of the American Medical Association* in which they originally appeared, **156:** 1177-1181, Nov. 20, '54.—**Ed.**

THE AMERICAN PHYSICIAN AND WORLD HEALTH

Ernest Wolff, M.D., and Leona M. Bayer, M.D.*

A look at the world shows all too clearly that it is a troubled globe, that the international scene is in profound upheaval. Too many peoples and too many nations are struggling for goals that are apparently incompatible. The United Nations seems to be faced with insurmountable problems to whose solution physicians can hardly hope to contribute. But when one looks at the world again through the spectacles of professional training, some familiar social patterns emerge. Most of the turmoil seems to emanate from areas of the world in which most of the people are sick and poor. Sickness and poverty and demonstrations of their interrelationship belong to everyday practical experiences. The slogan, "sickness makes men poor; poverty makes men sick; healthy people can end their poverty," appeared as the theme of a 1952 WHO newsletter.[1] Sickness and poverty are not only related but are everywhere joined together with the other well-known afflictions of hunger and ignorance. Interestingly enough, the ignorance is not so profound as it used to be. Knowledge has come to the far corners of the earth—not enough knowledge to solve the existing problems but enough to convince the sufferers that their problems are soluble. Everywhere, persons who are sick, poor, hungry, and ignorant, are looking for the technical aid that will break their cycle of misery. If aid is forthcoming, as it finally is in Indonesia, nations can proceed peacefully along the path of social progress. If aspirations are frustrated, goals are sought with violence, with war, with whatever alliances are available, and with increasing social chaos.

Having recognized a syndrome of grave social malaise caused by deprivation, it is time to apply scientific training to a consideration of the cure. American physicians can claim their right to suggest reasonable prescriptions based on rational diagnoses. In fact, there is reason to believe that technical aid and international development programs are as much specifics for the ills of the body politic today as antibiotic and chemotherapeutic agents are specifics for the diseases to which they apply. Incidentally, it is satisfying to note that many of the drugs and methods that are the foundation of the great campaigns and preventive programs now being conducted by WHO are either American discoveries or are being mass developed by American techniques.

Challenge of World Health

From the physicians' viewpoint, the world has taken on a relatively cheerful and purposeful aspect. The outstanding movement of modern history seems to be forward; the outstanding contemporary fact is the ever greater enfranchisement of submerged peoples. The United Nations, especially through its technical aid programs, functions as a democratic institution for helping history along its destined path. The World Health Organization is an important and popular agency of this institution. As such, WHO merits the interest of the American physician, whether by direct participation or by active support. Opportunities for direct participation are limited by personal, professional, and official consideration, but opportunities to act as public relations experts for WHO are unlimited. The physician is in a strategic position to promote public interest through the medium of citizens committees for WHO. In 1951, the National Health Council and the American Association for the United Nations jointly sponsored the organization of the National Citizens Committee For The World Health Organization, whose express purpose is "to increase through educational efforts public knowledge concerning the work of the World Health Organization, appreciation of the importance of international health programs, and understanding of the relation of public health issues involved to the general welfare of the world community."[2]

*From the Mount Zion Hospital (Dr. Wolff) and Stanford University School of Medicine (Dr. Bayer).

Read before the Section of Preventive and Industrial Medicine and Public Health at the 103rd Annual Meeting of the American Medical Association, San Francisco, June 24, 1954.

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INTERNATIONAL EDUCATION PROBLEMS

Hamilton H. Anderson, M.D.*

The purpose of this paper is to emphasize outstanding current problems in international education as they relate to medicine and the preservation of health, a task that is easier than offering uniformly feasible solutions. But before becoming involved in current efforts to solve health educational problems on the international level, it would appear desirable to specify objectives and to cite realistic attempts to attain them. It is my opinion that the ultimate objectives of international health education should be directed toward a better economic and health status of our friends abroad as a major contribution toward a safer world.

We cannot disregard the marked differences in health, nutritional status, and economic opportunities in countries outside the United States. Nor should one underestimate the influence of agriculture and engineering on nutrition, sanitation, and health in many areas of the world. Let us make a simple comparison of productivity in California and in India. In California, less than 15 percent of the people are engaged in agriculture, and they produce 40 percent or more of the fruits and vegetables consumed throughout the United States. In India, on the other land, 85 percent of the people till the soil and yet do not produce even enough to feed themselves. Factors other than ignorance of modern farming methods may be involved. Perhaps flood control, pest control (where pests may be considered sacred), and proper use of fertilizers and other soil conditioners may lead to a more productive system in India.

Approach to International Health Problems

An intelligent approach to international health educational problems requires knowledge of 1) critical health needs of peoples of various regions, 2) the environment in which health problems are bred and the probability of spread elsewhere in the world, and 3) control methods applicable to the individual patient, to his contacts, and to the community at large. The level of knowledge required in one region does not equal or even approach the level required in totally different environment.

Before people in any region, either inside the United States or outside, can enjoy a more abundant life, based on better nutrition, health, and economic status, at least the equivalent of an elementary school education should be available to all. For example, knowledge of the simple requirements of personal hygiene would do much to prevent treponematoses and other skin infections common throughout tropical areas of the Near East and the Americas.

To transplant students from abroad to our country and expect them to learn only the principles, without regard to the realities of their own environment in which they are to practice, is equivalent to providing men with brains and no hands. These men return as foreigners to their own countries.

Tropical Medicine

Few persons realize the full significance of environmental medicine and the increasing problems it presents. For want of a better name, this has been called tropical medicine, but realistically it is the environment in the home, community, state, nation, and region, and the level of sanitation and education in that environment, which influence occurrence of so-called exotic diseases and not the latitude or greater frequency within the tropics. The following quotation on this subject is of interest.[1]

> Alongside the topless towers of Point Four industrial dreaming, public health and rural sanitation seem a humdrum issue, something to be left to the Rockefellers and the missionaries. Actually they deserve first priority for economic as well as human reasons. The short life expectancy of an Indian (27 years) or of a Persian is itself their No. 1 national economic handicap and worst form of "underdevelopment," since it means—to put it coldly—that the average child born is destined to spend too much of its life as a drain in proportion to its years of productivity. To urge birth control is only to beg the question; for able-bodied adults are always a potential economic asset. . . . Public health programs made possible India's and Indonesia's enormous population growth, which is troublesome but not basic, for that growth measures the first stage of economic development.

Efforts of Near East Foundation

It is difficult to envisage how a few adequately trained technicians could enlighten great masses of people who do not have the basic understanding of community needs and responsibilities that an elementary education can provide. In Asia, the Near East Foundation has exerted its efforts, and with uniform success where others have failed. In 1930, as a successor to Near East Relief, the foundation began to improve the condition of agriculture in the countries of the eastern Mediterranean. An institute of rural life was established in the American University of Beirut, Lebanon, to "inspire landowners and tillers of the soil to co-operate in the use of scientific knowledge for the improvement

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of rural life." The primary objective of the foundation was the introduction of modern agricultural methods; but sanitation, recognition of social needs, and personal hygiene go along as partners and eventually spread throughout the village. With the full co-operation of each government concerned, the foundation has been astute enough to begin at the village level and develop intelligent youth as the center of the program, which the village identifies as its own.

It became apparent early in the work of the foundation that the current training of agricultural teachers in Lebanon and Palestine was too complex. Therefore, the Institute of Rural Life developed, and a volunteer unit known as the Village Welfare Society was born. Five day conferences were held among interested students and teachers, after which small groups went into southern Lebanon and Palestine to explore the possibilities of improving health, agriculture, home life, and recreation. The Near East Foundation's adviser and the Palestinian department of education gave their co-operation. It became a program of the country, as intended, and not one foisted on them by an outlander group, which would have been viewed with suspicion or hostility by the local people. As President Penrose[2] points out in his chronicle of the American University, within 10 years after its inception, there were more than 300 teachers and students who devoted much of their vacation and other free periods to this work. Almost all paid their own expenses for travel and maintenance. This was a truly humanitarian effort from the beginning.

These early endeavors of the foundation, though agricultural in ultimate objective, initially were related to the health and sanitation of the community. Thus, clinics and sanitary projects, such as lectures on public hygiene, removal of rubbish and piles of manure, and the building of latrines, were included. A major engineering project was developed at Jibrail to clean, drain, and protect the spring that supplied the village with water. In the Boqa'a Valley, a permanent health center was established, with nurses in residence throughout the year. This served as a nurses' field training area, at the joint expense of the American University of Beirut and the Near East Foundation. A physician from the American University made weekly visits. A boring machine, found in the district by volunteers, was put to use, and an artesian well was developed. This was an improvement over the previous source, an open canal used by cattle and washerwomen alike. The boring machine found similar good use in other neighboring communities.

The success of the village welfare services aroused much interest among both governments and individuals. The *Mukhtars* of the villages, the agricultural agent, and the administrator of the Boqa'a all played their parts, and without their wholehearted co-operation, little would have been accomplished. Later, village welfare services were developed in Syria and in Jordan. In each case, the government concerned invited volunteers from station camps established elsewhere. A chain reaction was set up that continues today in Iraq, Iran, and elsewhere in the Near East. In a measure, this effort was the beginning of what we now know as an agricultural extension division, with the establishment of farmers' co-operatives to increase land utilization and productivity.

One must understand the problems of the Near East, the complexity of environment with tropical and sub-tropical climate; the social stratifications; the heterogeneous religions of the area, as represented by Moslems, Christians, Druses, and Jews, all with their various sects and subsects; the many nationalities, Lebanese, Syrian, Iranian, and so on; the varying economic and social strata, where the poor predominate and the "ignorant live in an atmosphere of economic and educational feudalism."[3] To this complex situation must be added psychologic influences, such as individualism, fatalism, and a sense of insecurity and inferiority. These factors are superimposed on years of exploitation by "balance of power" machinations of a warring world that had largely passed them by. In such a milieu, it is difficult to recognize and control commoner communicable diseases, let alone the more complex health problems.

Peiping Union Medical College

During the 20 years of its existence (1924-1943), the Peiping Union Medical College, established in Peiping, China, by the China Medical Board, had developed an enviable reputation as a first rank institution. When the Rockefeller Foundation, through the board, decided to provide the people of China with the best type of medical and nursing education, it was recognized that more than 10,000 physicians should be available for the 450 million people of China. Rather than duplicate the somewhat mediocre job being done by existing institutions, it was felt that an internationally recognized staff of the highest caliber should be assembled to serve as a western model for the continent of Asia. The best possible facilities were built to meet the exacting needs of the staff and students. Even today, the facilities compare favorably with the best found elsewhere in the world. Unfortunately, first the Japanese invasion and presently the communist domination of China have cut short the enviable record of Peiping Union Medical College.

Comments

International health educational programs are, above all things, a team job, and often the local government cannot handle these programs without outside help. But even with internationally recognized specialists on loan from the World Health Organization or the Foreign Operations Administration, and with financing from outside sources, they must still remain projects of the country and community. If fully identified as spawned by the local government, they may have permanence and definite follow-through.

The primary level of health educational efforts should depend on the degree of development of the country or region concerned. In less well-developed areas, education should begin at the village level, making use of the experience of the Near East Foundation and other regional training programs. In better developed areas, the regional public health program should serve as an example. In more progressive areas, where teacher training and advances in knowledge may be the goals, the Peiping Union Medical College represented the best example during the short period of its existence. In all such programs, training of local personnel and the designation of the program as a local or regional project have been the keys to success. Regional educational facilities are first explored and utilized. If they are not completely adequate, experts and technicians are brought in to train auxiliary personnel. Key professional personnel may receive training abroad and thus be aided by specialized facilities. In exchange, visiting lecturers and field workers from the Foreign Operations Administration or the World Health Organization may serve to initiate programs in regions where they are completely conversant with local problems.

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INTERNATIONAL HEALTH ORGANIZATION

Fred L. Soper, M.D., Dr. P.H.*

Dr. Wyckliffe Rose, director of the International Health Board of the Rockefeller Foundation from 1913 to 1923, defined the objective of international health as an attempt to bridge the gap between available medical knowledge and the application of that knowledge in public health practice throughout the entire world.

International Collaboration in World Health

When the constitution of the World Health Organization (WHO) was written in 1946, specific functions were assigned in three general categories: 1) functions relating to international sanitary regulations; international nomenclature of diseases, causes of death, and new drugs; and the determination of international standards for pharmaceutical and biological products; 2) co-ordination of health activities of governments and of other international agencies for the eradication of epidemic and endemic diseases, the promotion and conduct of research in the field of public health, and the promotion of improved standards in the medical and related professions; and 3) assistance to governments in strengthening national health services; furnishing technical assistance; promotion of improved nutrition, housing, and sanitation; and the promotion of maternal and child health. This broad range of functions of the World Health Organization is essential to the developing concept of international health as a most important element in promoting world peace.

Historically, international collaboration in health was originated to meet the need for organized prevention of the movement of epidemic diseases along international trade routes and to supplant arbitrary quarantine measures, always costly and often ineffective, that had been used for hundreds of years as a defense against the real or imagined threat of importation of such diseases as cholera, smallpox, typhus, and yellow fever. Today the increased rapidity and volume of travel by air largely invalidates frontier and port measures for protection against the importation of communicable diseases.

*From the Pan American Sanitary Bureau, Regional Office for the Americas, World Health Organization.

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The only satisfactory solution is their eradication in those countries where the seeds of infection persist. Obviously then, the United States and other countries that are relatively free of epidemic diseases have an increasingly important stake in the proper development of health programs everywhere. However, the chief preoccupation in the United States is not with the communicable diseases of other countries, as they may threaten this country, but with the general health of the peoples of the so-called underdeveloped areas of the world.

Recently it has become apparent to serious students of world affairs that existing health conditions throughout the underdeveloped areas of the world contribute greatly to the unsatisfactory economic and social conditions responsible for disrupting world peace and threatening international security. Quite apart from any moral interest, it is essential that the great disparity in health conditions in different parts of the world be righted as a means to the reduction of political stress.

Role of United States

The United States has both a direct health interest and a political stake in the improvement of health in other countries. This interest and this stake are equally great for the other well-developed countries of the world, but the responsibility of the United States is greater because of its greater economic and professional resources. The United States government has recognized this responsibility and in addition to its participation in the Pan American Sanitary Bureau and the World Health Organization, has, since 1942, maintained its own organization, Institute of Inter-American Affairs, widely known as the IIAA, for promoting health programs in Latin America. In recent years, under the Economic Cooperation Administration, the Technical Cooperation Administration, and Mutual Security Agency, similar organizations have been developed for other parts of the world, all of which now operate under the Foreign Operations Administration (FOA). Also the United States has contributed most liberally to the Children's Fund and to the Technical Assistance Fund, both voluntary funds of the United Nations. The Technical Assistance Fund for Economic Development, devoting part of its resources to health, was, in fact, created at the suggestion of the United States.

International Health Organization

The multiplicity of organizations through which the U.S. contributes to international health programs causes a certain amount of confusion among other contributing governments and among the health authorities of countries receiving assistance. In addition, there is a considerable increase of overall administrative costs in this field. It is not logical, however, to anticipate that the present situation will continue for an indefinite period. Other contributing governments understand readily the United States contribution of 100 percent to the programs administered by U.S. officials but find it difficult to fathom our willingness to contribute three times as much to the fund for child health as to the fund for general health programs, at a rate of 70 percent as against 33⅓ percent for the World Health Organization. The health authorities of a given country, in order to take full advantage of all possible sources of aid, financed wholly or in part by the United States, find themselves at times negotiating agreements with officials of the United States government, with representatives of the Children's Fund of the United Nations, with representatives of the Technical Assistance Fund of the United Nations, and with the World Health Organization. The conditions of collaboration vary according to the source of funds. The situation is further complicated by the fact that WHO is responsible for the technical orientation and approval of the Children's Fund projects and for the planning and administration of the Technical Assistance Fund's health program. From the standpoint of the authorities of the receiving countries, collaboration with the World Health Organization is the most acceptable, both technically and politically.

United States Contributions to International Health in 1954

Agency	%	Amount
World Health Organization	33⅓	$3,000,000
Technical Assistance U.N.	60	$2,640,000
Children's Fund of U.N.	70	$9,880,000
Health Programs of FOA	100	Scores of millions of dollars

World Health Organization

The World Health Organization is a specialized technical agency of the United Nations system but under a separate treaty, with membership independent of membership in the United Nations and with its own governing assembly. The World Health Assembly, which can be seen in operation in Mexico City in May 1955, is composed of technical representatives of member states. The assembly meets annually to determine policies, approve programs,

and provide for financing operations through assessments on member states. For operational purposes, WHO has been divided into six regions, of the Americas, Europe, Africa, eastern Mediterranean, southeast Asia, and the western Pacific.

In the Americas, the Pan American Sanitary Bureau, with headquarters in Washington, D.C., serves as the regional office of the World Health Organization. Only in the field of health have the specialized agencies of the United Nations and the Organization of American States joined in a common administration and in a common program.

Comment

A long-term continuation of the present complex situation in international health is not logical. Neither is it possible to anticipate any immediate solution. Only as the special groups, such as the medical profession, come to understand the importance of international health to the welfare of the United States and become familiar with the needs and opportunities of the different organizations in this field will it be possible to get an authoritative, disinterested professional voice on the subject.

INTERNATIONAL MEASURES AGAINST TROPICAL DISEASES

Frederick J. Brady, M.D.*

The United States is participating in a number of international health programs that help countries strengthen national and local health services. Previously, I have outlined the framework of United States participation in international measures against diseases of worldwide importance, particularly diseases that predominate in tropical and economically underdeveloped areas. Recent trends and developments in respect to these diseases show good results. The network of international multilateral and bilateral health organizations is slowly lifting the burden of disease. In some instances, eradication appears near.

Declining Incidence of Smallpox

Of all the pestilential diseases, smallpox has been considered more important to the United States than any other because of its ready transmission by international travelers. Our best protection against its introduction is elimination of endemic foci, particularly those near our frontiers. As a result of national and international health measures, the northern half of the Americas is almost free of smallpox.[1] This disease has not occurred in Alaska, Hawaii, or Puerto Rico for eight years. Last year, five cases were reported in the continental United States, but there is considerable doubt as to whether any of these cases were smallpox. Mexico reported no cases in 1952 or 1953, and the Caribbean area has been free of smallpox since 1949. In Central America, a few cases still occurred in 1953 in Guatemala and Nicaragua, but no cases have been reported from El Salvador, Costa Rica, or Panama for several years. Smallpox is still widespread in many areas of South America, although much of it is a milder form called alastrim. Europe can be considered to be free of smallpox except for an occasional outbreak due to infection brought in from other areas. Some endemic areas may still exist in Portugal and Spain. Oceania, including Australia and New Zealand, is free of smallpox. In general, smallpox is still very prevalent throughout Africa in the area south of the Sahara and in various parts of Asia.

In the last two years, the Pan American Sanitary Bureau has earmarked about $200,000 to assist in the control of smallpox. Major emphasis is being placed on the development of a good, dry vaccine and assistance to national laboratories in making vaccines. It is expected that these programs will materially assist countries in eliminating the endemic foci of the disease. It is now safe to conclude that smallpox has been eradicated from large areas of the world, and, undoubtedly, it will soon be eradicated from other areas. Complete eradication is dependent on the development of adequate public health services in countries where it is endemic. With the assistance of international health measures and organizations, these services are being strengthened.

Control of Malaria

Malaria remains the greatest single cause of debilitation and death throughout the world. Latest estimates[2] are that 350 million persons still suffer from malaria each year, and 10 percent of these cases may be fatal. The development of residual spraying and of international health measures is accelerating the rate at which malaria is receding.

*From the Division of International Health, Bureau of State Services, Public Health Service.

Read before the Section on Preventive and Industrial Medicine and Public Health at the 103rd Annual Meeting of the American Medical Association, San Francisco, June 24, 1954.

Malaria was eradicated from the United States a few years ago, although there have been several minor outbreaks caused by cases contracted outside the country. In the Americas, a number of countries are well on the way toward eradication of malaria and the remaining countries are starting control campaigns. It is estimated that two thirds of a total population of over 100 million persons in danger of malaria in the Americas are now receiving protection against the disease.

Malaria has virtually disappeared from Europe, with only a few cases occurring in Greece, Portugal, and Spain. The disease is endemic in much of Africa in the area south of the Sahara. The world's biggest malaria problem, however, remains in Asia, where there have been many local campaigns but only a few directed toward nationwide eradication, as in Ceylon and Lebanon, which are now free of the disease within their relatively small areas. With help from WHO, UNICEF, and the United States, India has launched a far-reaching malaria control campaign aimed at eventual protection of 200 million persons in malarious areas. Within the next few years, Thailand anticipates effective, nationwide control of malaria without any further outside assistance.

Control of malaria through the use of residual sprays costs about 25 cents per capita each year. If spraying is kept up for several years in a large enough area, the disease disappears. There is a growing concern, however, over the possibility that inadequate control programs may be producing strains of Anopheles that are resistant to insecticides. There is laboratory evidence that one strain of Anopheles has become resistant to chlorophenothane (DDT) and epidemiological evidence that two species have become similarly resistant.[3] If programs in some areas are discontinued prematurely or are inadequate in scope, the cost and difficulty of controlling malaria will be greatly increased. This unfortunate contingency can be prevented by adequate long range planning by governments committed to carry out their responsibilities. The World Health Organization is making every effort to obtain such plans and commitments.

Declining Rate of Other Diseases

There have been several significant developments with respect to yellow fever in the last few years. Yellow fever in human beings does not exist in the Americas except as man becomes an accidental host for the virus harbored in monkeys and nondomestic jungle mosquitoes. Within the last four years, jungle yellow fever has been spreading northward from Panama and has now reached Nicaragua and Honduras. Similarly, in South America, jungle yellow fever has had a recrudescence in southern provinces of Brazil and into Argentina.[1] It is fortunate that campaigns that have led to the eradication of Aedes aegypti have been so successful in areas where the epizootic has struck. However, research at the Gorgas Memorial Laboratory in the Republic of Panama revealed that the epizootic in Central America was occurring outside of the areas where the known mosquito transmitters of jungle yellow fever occur. It is evident from this that we cannot predict the ultimate extension of the disease, because the transmitting agent is unknown.

In Africa, the other area of the world where yellow fever occurs, sporadic cases are reported in human beings, and, according to mouse-protection tests, the disease probably is widespread throughout Africa in both its jungle and domestic forms.[4] For reasons unknown there is no yellow fever in the whole southern part of the continent of Asia. It would appear that the introduction of the disease would have disastrous results. Such a situation has its repercussions when nations try to devise worldwide, uniform quarantine regulations. At the most recent World Health Assembly in May 1954, the degree of protection requested by these Asiatic countries caused a great deal of debate. Resolved to its lowest denominator, the issue, as seen by the majority, concerned the degree of travel restrictions required to give the protection demanded by the countries of southern Asia. The decision taken was one that would consider much of the Americas in the endemic yellow fever zone and therefore subject to travel restrictions, in spite of the fact that the yellow fever prevalent in South America and Central America is the jungle type and the risk of a traveler transmitting it to Asia is remote.

Another tropical disease that has been subject to international action is treponematosis (yaws). It is a very incapacitating disease that has far-reaching effects on the economy of the areas in which it occurs. An estimated 20 million to 30 million persons have yaws. Among the major foci of this disease are Haiti, Ecuador, and Colombia in this hemisphere; Indonesia, Thailand, and Malaya in Asia; and Central Africa. Fortunately yaws can be cured readily with penicillin, and in this hemisphere a single dose has been found to be adequate. The results of penicillin treatment are dramatic; healing starts almost immediately after the injection, and patients not permanently crippled regain their economic usefulness. Through the control campaigns of the World Health Organization and UNICEF, about 4,500,000 patients and contacts have been treated in the last three years. The results of the campaign have been particularly striking in Haiti, where control measures are reaching the stage

of ferreting out the last cases, to be followed by surveillance to ensure against further outbreaks of the disease. During the campaign, the costs of treatment per person have consistently decreased from about $3 to $1 a case.

In much of the world, tuberculosis is still a major problem. The newer techniques of case-finding have not had widespread application, primarily owing to a lack of facilities for treating diagnosed cases; however, the World Health Organization and UNICEF have undertaken extensive campaigns throughout much of the world to supply some 20 million persons with BCG vaccine. It may still be premature to attempt to forecast the long-term effect of this program in controlling tuberculosis. Bovine tuberculosis has now been practically eliminated from the United States and from the Scandinavian countries. Its occurrence in the United Kingdom is rapidly dropping; however, there is still a high incidence in Europe and probably in the rest of the world. In some areas, 10 percent or more cases of tuberculosis in man are caused by the bovine type.

In a few places in the world, rabies has been virtually eradicated. Malaya has had no rabies since July 1953,[5] and in Israel the vaccination of dogs has brought the incidence of rabies almost to zero.[6] These results are attributed to a more effective canine vaccine. Trials of a new antiserum in Iran for human use have shown that this therapy gives immediate passive protection and does not detract from the development of active immunity by the use of rabies vaccine. In the United States, there is a growing concern over bat rabies. Herbivorous rabid bats have been found in several southern and eastern states, and there is real evidence that rabies-transmitting vampire bats are moving northward in Mexico to within a few miles of the United States border. In fact, there is indirect evidence that vampire bats are already in the United States. Vampire bats are efficient vectors of rabies and not only serve as a wild reservoir of the virus but also frequently transmit the disease to cattle.

A little-known disease in the United States, kala-azar, or visceral leishmaniasis, was acquired by considerable numbers of United States troops during World War II. The disease is readily treated by antimony compounds but is refractory to the commoner drugs in the physician's bag. The tragedy of these cases was the lack of early recognition and specific therapy. UNICEF has assisted in the control of kala-azar in India, where a major focus of the disease occurs.

Schistosomiasis is another disease that is receiving international attention. This disease occurs primarily in parts of South America, in Japan, and in the whole of Africa. It has several unfortunate attributes. Cases in human beings are difficult to treat; it is a chronic incapacitating disease, and control is difficult because it is transmitted through the skin of persons who are exposed to water containing the free-swimming, liberated cercariae from fresh water snails. In the Japanese form, at least, domestic animals serve as reservoir hosts. Until recent years there has been little hope for an effective control measure against schistosomiasis. However, laboratory and field studies at the National Institutes of Health have shown that certain chlorinated phenols can be applied to water that are safe for man and domestic animals but will kill the snails in dilutions of less than 10 ppm. These compounds have been found to kill even snail eggs. If further work confirms these preliminary results, the disease can be eliminated from areas where it now occurs. Its eradication would have far-reaching economic influence on a country such as Egypt, where it is an occupational hazard and where in some areas 95 percent of the inhabitants are infected and many are incapacitated. Both the World Health Organization and the Foreign Operations Administration have teams in the field learning how to use these new compounds effectively.

Another vicious disease receiving attention is hydatid disease, occurring in southern South America, eastern Mediterranean area, Australia, and New Zealand. Although due to an animal parasite, the disease in man takes on many of the characteristics of a malignant lesion, such as metastasis and recurrence, unless it is completely extirpated from the body. In controlling this disease, the international organizations have learned that it is possible to cure dogs that harbor the adult stages of the parasite so that they will no longer infect persons. Along with this, countries have been helped to institute good meat inspection practices that remove the source of the infection for dogs.

References

[1]Stowman, K., World Prevalence of Quarantinable Diseases, Field Memorandum No. 6, revised, Division of Foreign Quarantine, Bureau of Medical Services, Public Health Service, March 1954, pp. 12-14.

[2]Russell, P. F., Personal communication to the author.

[3]Pampana, E. J., Personal communication to the author.

[4]Expert Committee on Yellow Fever, Second Report, Official Records No. 56, Geneva, Switzerland, World Health Organization, 1954.

[5]Kuala Lumpur, Malaya, Foreign Service Despatch 300, Department of State, April 1954.

[6]Joint FAO/WHO Expert Committee on Rabies, Second Report, Technical Report Series 82, Geneva, Switzerland, World Health Organization, September 1953.

World Health Organization

THE 999 CATEGORIES under which all types of disease, injury, and death are at present recorded by modern statisticians were reviewed and brought up to date at an intergovernmental conference convened by the World Health Organization in Paris on February 21, 1955.

The conference sought to complete the seventh revision of the International Lists of Diseases and Causes of Death.

Improvement of statistics relating to the incidence of diseases in advanced countries, and of statistics showing causes of death in underdeveloped areas, were also discussed. It is necessary to discover more precisely which are the ailments costly to the community and the chronic diseases of modern man, and the chief causes of death among more primitive populations. This knowledge is vital for a proper concentration of efforts on the part of health services in both types of communities.

The usefulness of a uniform classification of causes of death was recognized a century ago when, in 1853, the first International Statistical Congress, held in Brussels, called for a uniform and comparable list of causes of death that could be used in all countries. The first international list was drawn up at a congress in Paris in 1855. The first such list to be generally adopted came into use in 1893. Since that date, under the auspices of the French government, six revisions have been made at intervals of approximately 10 years.

When the World Health Organization was created, it was entrusted with the task of continuing the revision of the "Death Lists," as well as with the establishment of lists of diseases and injuries. This work was performed between 1946 and 1948 by the WHO Interim Commission. The First World Health Assembly, in 1948, adopted WHO Sanitary Regulation No. 1 which ensures international application of the Classification of Diseases, Injuries, and Causes of Death as a single and comprehensive list. Since then, a great deal of work has been done by WHO member states to improve the collection and interpretation of their statistics on causes of death as well as on non-fatal diseases and injuries.

The greatest difficulties are encountered in regions where health services are in their infancy and where there is barely one physician for 100,000, or even 200,000 people (as opposed to one per 1,000 in most of Europe and North America). Even rudimentary statistics relating to causes of death are lacking for 85 percent of Africa, 40 percent of America, 70 percent of Asia, 15 percent of Oceania, WHO records indicate.

As these are precisely the regions where information is most urgently needed to determine the basic health needs of the population, the WHO conference in Paris considered the possibility of drawing up simple lists of causes of death which could be filled out by non-medical personnel in underdeveloped areas. Village headmen, tribal chiefs, and other local authorities could record crudely, according to very simple lists, the causes of deaths which have occurred among their people. The lists would include simple titles such as: deaths of babies, of women in labor, of old people, or deaths from "the fevers," wounds or snakebites. Although rudimentary, such data could be fairly accurately interpreted by epidemiologists for the benefit of health authorities.

In developed areas, causes of death are usually known and recorded in a satisfactory fashion, WHO commented, but more information is needed about non-fatal diseases which are widespread and represent a serious economic burden. Rheumatism, mental disorders, and chronic illnesses of different kinds are a serious concern to insurance companies and social security organizations. More knowledge as to their real incidence is needed to enable health authorities to take appropriate steps including the planning of preventive measures and treatment facilities.

* * *

Five more international associations have been admitted to official relationship with the World Health Organization by its Executive Board. The action brought to 35 the number of non-governmental organizations interested in health work which the World Health Organization has admitted to official relationship.

The newly accepted organizations are: the International Union of Health Education of the Public, the International Hydatidological Association (which deals with hydatid disease, a parasitic disorder), the International Society of Criminology, the International Society for Blood Transfusion, International Organization against Trachoma.

American Medical Women's Association

PRESIDENT'S MESSAGE

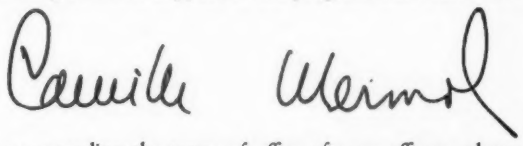
THE ANNUAL MEETING is only a few days away, when Dr. Esther Marting will take over the Presidency of our Association.

I wish, at the present time, to bring my very sincere thanks to all of you who have helped me throughout this year. It is impossible for me to give all the names, but I want to express my special gratitude to those who have accepted committee assignments. Outstanding amongst those are: Dr. Elizabeth Waugh and the Publications Committee; Dr. Elizabeth Brackett and the Finance Committee; Dr. Edith Petrie Brown and the Membership and Organization Committee; Dr. Ann Gray Taylor and the Scholarship Loan Committee; Dr. Esther Lovejoy (may her shadow never grow thin!) and her Service Committee; Dr. M. Eugenia Geib, Editor, and the Assistant Editors and staff of the JOURNAL; and my immediate predecessor, Dr. Judith Ahlem, who is handling so capably the intricate affairs of the Mühl Estate.

The work of all of us has been made infinitely easier by the untiring labor of Mrs. Majally and her assistants in the national office.

Let us all continue to work with this Association and give active support to the program that Dr. Marting will present.

My cordial good wishes to every one of you.



P.S. Urgent: If you have not answered the questions regarding the terms of office of your officers, please turn to advertising page 30, and send your answers at once to the AMWA office at 1790 Broadway, Room 409, New York 19, New York.

ANNUAL MEETING
June 2-5, 1955
Hotel Dennis, Atlantic City, N.J.

Thursday, June 2

8:30 a.m.-12:00 noon—Organization and Membership Committee—Gold Room
9:00 a.m.—Registration—Lower Lobby
9:00 a.m.—Publications Committee — Borton Room
11:00 a.m.—Finance Committee—Art Studio
2:00 p.m.—Executive Committee Meeting — Borton Room

Other committee meetings as arranged by the chairmen

Friday, June 3

9:00 a.m.—Registration—Lower Lobby
9:30 a.m.—Board of Directors—Gold Room
10:30 a.m.—General Session—Garden Lounge
12:30 p.m.—Luncheon—Ozone Suite
3:00 p.m.—General Session—Garden Lounge
7:30 p.m.—Banquet—Ozone Suite
Woolley Memorial Lecture: Dr. Lydia Giberson—"The Role of Industrial Medicine in a Human Relations Program"

Saturday, June 4

9:00 a.m.—Registration—Lower Lobby
9:30 a.m.—General Session—Garden Lounge
12:30 p.m.—Luncheon—Ozone Suite
Panel Discussion: Industrial Medicine
3:00 p.m.—General Session—Garden Lounge
7:30 p.m.—Inaugural Banquet—Ozone Suite
Inaugural Address: Dr. Esther C. Marting—"The Horizon"

Sunday, June 5

9:30 a.m.—Executive Committee Meeting — Garden Lounge
10:00 a.m.—Board of Directors Meeting — Garden Lounge
10:30 a.m.—Open Meeting — "Activation of 1955-1956 Plan of Work"—Incoming committee chairmen

Coffee Hour—at all morning sessions—Courtesy of Dr. Esther C. Marting
1:30 p.m.—Film Preview — Industrial Medicine—Garden Lounge

(If you have not already done so, please fill out the following forms: Room Reservations—advertising page 28; Meal Reservations—advertising page 32; Membership Directory—advertising page 36.)

Social Doings

Friday, June 3

12:30 p.m.—Luncheon—Ozone Suite

7:30 p.m.—Banquet—Ozone Suite—Woolley Memorial Lecture

Saturday, June 4

12:30 p.m.—Luncheon—Ozone Suite—Discussion of Industrial Medicine

6:30 p.m.—Cocktails—Ozone Lounge—compliments of Ortho Pharmaceutical Corporation

7:30—Inaugural Banquet—Ozone Suite

Sunday, June 5

Coffee Hour—all morning sessions—courtesy of Dr. Esther C. Marting

Wednesday, June 8

6:00 p.m. to 7:00 p.m.—Mead Johnson & Company invites all women doctors attending the Annual Meeting of the AMA to a reception at the Claridge Hotel, Windsor Lounge

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ALUMNAE DAY AT THE NEW YORK INFIRMARY

June 2, 1955

Alumnae Day is sponsored by the Medical Alumnae Association of the New York Infirmary. There will be morning and afternoon clinical sessions and round-table discussions from all the departments. The subjects will be announced later. Lunch will be served at the hospital. There will be an alumnae dinner and business meeting in the evening.

The place is the beautiful new building which opened in August 1954, the New York Infirmary, Stuyvesant Square East and 15th Street (321 East 15th Street), New York 3, New York. This building is on the same site as the old one which for years had needed to be replaced.

The Alumnae Association of the New York Infirmary includes all doctors trained at the Infirmary and all those who have been members of the medical staff. Plan to come even if you are not now an active member. **All women doctors are invited.** Stop on your way to the medical conventions in Atlantic City.

If you plan to be present on Alumnae Day and at dinner and/or you are interested in receiving news about the New York Infirmary, send a card to Dr. E. Catherine Cline, Secretary, Medical Alumnae Association, c/o New York Infirmary, 321 E. 15th St., New York 3, New York.

NEWS FROM THE BRANCHES

Branch Eleven, Southwestern Ohio

A meeting of the Cincinnati Medical Women's Club was held on February 22, 1955, at the Good Samaritan Hospital auditorium. Dr. Edward Ball lectured on "Pediatric Dental Problems."

Branch Nineteen, Iowa

Dr. Mary Louise Lyons, Northwest Central Regional Director, and Dr. Madelene M. Donnelly gave a buffet supper for all women physicians and interns in Des Moines on February 15, 1955, at the home of Dr. Donnelly. The gathering was well attended.

Opportunities for Women in Medicine

PUBLIC HEALTH

The field of public health and preventive medicine offers many opportunities for the physician entering practice or contemplating a specialty or a change in type of practice. Physicians are needed in health departments—state, county, and city—not only in California but also throughout the United States.

Public health and preventive medicine is a recognized specialty in medical practice with a specialty board, the Board of Preventive Medicine, similiar to other specialty boards. In addition to his medical responsibilities, a health officer also has administrative duties and responsibilities for the direction of the various programs for the protection of the health of the general public. This requires the health officer to become acquainted with such related subjects as epidemiology, sanitation, vital and morbidity statistics, health education, and specialized research, in addition to his knowledge of clinical medical practice, and thus provides a wide and interesting field for professional activity.

The principal position in local departments is that of health officer. Other medical positions are assistant health officer, district health officer (in the largest departments), and program directors or assistants in special fields such as tuberculosis, venereal disease and acute communicable disease control, epidemiology, maternal and child health, occupational health, and others. Comparable positions exist at the state and federal levels of government.

The physician in public health is concerned primarily with the preventive rather than the therapeutic aspects of medicine and with the promotion of health rather than the cure of disease. His patient is the community rather than the individual, but his objective, as in all the other fields of medical practice, is to save human life and protect the individual from the disabilities and handicaps resulting from ill health.

California

California is approved for residency training and a limited number of scholarships are available through the State Department of Public Health both for residencies and for postgraduate education in a school of public health.

Positions are open in California both prior to specialty recognition and afterward.

At present in the 53 local health departments and in the state health department, there are 226 medical positions.

During the year ending September 30, 1954, there were 51 physicians appointed to positions in these health departments.

Vacancies occur throughout the year.

The majority of starting salaries of local health officers vary from $800 to $1,400 a month. Maximum monthly salaries after a few years of service will run several hundred dollars higher.

Assistant health officer positions range from about $600 to $1,200 per month with several hundred dollars increase after the first few years.

Positions for other medical officers range from about $600 to $750 per month with increases rising from $150 to $200.

For further information, write to Dr. John C. Dement, State Department of Public Health, 2151 Berkeley Way, Berkeley, California.

Public Health Scholarships

There is currently a shortage of physicians and other professional workers trained in public health, so much so that the Harvard School of Public Health has inaugurated a scholarship program to encourage graduates in medicine, dentistry, veterinary medicine, public health nursing, health education, and other specialties, so that students may further their educations or seek careers in the field of public health and preventive medicine.

That public health is recognized as a specialty in medicine is evidenced by the creation several years ago of the American Board of Preventive Medicine. One of the prerequisites for certification is "successful completion of at least one academic year of graduate study leading to the degree of Master of Public Health or an equivalent degree or diploma or an equivalent training satisfactory to the Board."

Scholarships for the Harvard academic year 1955-1956 will be granted to individuals of high professional promise in awards ranging from part tuition to tuition plus a stipend, according to the qualifications and financial needs of the applicants. The scholarship funds are limited and are intended primarily for citizens of the United States.

Scholarship applicants must be eligible for admission to the school as a candidate for one of the following degrees: Master of Public Health, Doctor of Public Health, Master of Science in Hygiene,

Doctor of Science in Hygiene, or Master of Industrial Health.

Scholarships are available to those in the following categories who wish to obtain postgraduate education in the field of public health or in one of the basic sciences related to public health:

1. Physicians, dentists, and veterinarians
2. Industrial physicians
3. Public health nurses with a college degree and satisfactory field experience.
4. Social workers with a Master's degree from an approved school of social work and acceptable experience in the field of medical or psychiatric social work.
5. Health educators with the following background: college degree, training either in health education or in the natural and social sciences, experience in general education or community health.
6. College graduates who have concentrated in one of the natural sciences or in engineering (environmental aspects).

A catalogue of the school, admission and scholarship applications, and further information may be obtained by writing the Secretary, Harvard School of Public Health, 55 Shattuck Street, Boston 15, Massachusetts. Scholarship applicants must return completed admission and scholarship applications to the Harvard School of Public Health.

SCHOLARSHIP

Physicians, therapists, educators, and other professional workers may qualify for scholarships for special study of cerebral palsy provided by Alpha Chi Omega, national women's fraternity, and the National Society for Crippled Children and Adults. This scholarship program, which has been in effect for six years, will continue until September. Qualified professional persons will receive allotments for tuition and maintenance at recognized training centers for a minimum of three months. Grants vary between $100 and $750. Students are expected to cover their own expenses involved in travel to and from their homes. Applicants are expected to make their own arrangements for acceptance at an approved training center offering specialized training in cerebral palsy. Applicants who receive awards will be expected to work in some bona fide program for the cerebrally palsied for at least one year on completion of their training. For information one may address: Training and Employment Service, National Society for Crippled Children and Adults, Inc., 11 S. LaSalle St., Chicago 3.

CHILD PSYCHIATRY

Specialized training in child psychiatry is available in a number of member clinics of the American Association of Psychiatric Clinics for Children that have been approved as training centers by the association. The training begins at a third year, postgraduate level with minimum prerequisites of graduation from an approved medical school, an approved general or rotating internship, and a two year residency in psychiatry, approved by the American Board of Psychiatry and Neurology. Most of these clinics have also been approved individually by the American Board of Psychiatry and Neurology for a third year of training and for an additional year of experience. This training is in preparation for specialization of child psychiatry and, especially, for positions in community clinics devoted wholly or in part to the outpatient treatment of children with psychiatric problems. Fellowship stipends are usually in line with U. S. Public Health Service standards; that is, about $3,600. A limited number of training centers can offer higher stipends. The office of the American Association of Psychiatric Clinics for Children acts as a clearinghouse for applicants. Application may be made through this office or directly to the individual clinics. Information may be obtained from Miss Marion A. Wagner, Administrative Assistant, American Association of Psychiatric Clinics for Children, 1790 Broadway, Room 916, New York 19.

FELLOWSHIP

The Earl D. Osborne Fellowship, sponsored by the American Academy of Dermatology and Syphilology, will provide annually the opportunity for training in dermal pathology to a postgraduate student who has completed at least one year of training in dermatology. The stipend is $4,000 a year, divided into four quarterly payments during the year's fellowship. The period of training will be spent at the Armed Forces Institute of Pathology, Washington, D.C., the appointment being subject to approval by the director of the institute. The student must complete one year of graduate training, either before or after completion of the Osborne fellowship, in an institution approved by the board for three years of training. Application blanks may be obtained from Dr. Hamilton Montgomery, Chairman, Committee on Pathology, American Academy of Dermatology and Syphilology, 200 First St., Southwest, Rochester, Minn. The next available appointment begins July 1.

* * *

The national office of the Hemophilia Foundation announces the establishment of a fellowship in hematology at the Mount Sinai Hospital in New

York. This award is intended to provide opportunity to interested physicians for clinical and laboratory study in disorders of coagulation. The fellowship of $3,600 will be awarded annually, the first to commence as of July 1. Information may be obtained from the Medical Secretary, Hemophilia Foundation, 60 E. 42nd St., New York.

PRIZE

The Francis Amory Septennial prize of the American Academy of Arts and Sciences is offered "for outstanding work addressed to the alleviation or cure of diseases affecting the human reproductive organs, in particular those of men." The work may be instrumental technology, operative procedure, clinical or laboratory research, or a technical treatise. No formal applications and no essays or treatises from candidates are desired, but nominations, supported by statements of qualifications in respect to work consummated between Nov. 10, 1947, and Nov. 10, 1954, will be given careful consideration. The amount of the award is in excess of $20,000. Nominations should be sent to the American Academy of Arts and Sciences, 28 Newbury St., Boston.

MEETING

The twenty-first annual meeting of the American College of Chest Physicians will be held at the Ambassador Hotel, Atlantic City, New Jersey, June 1 through 5, 1955. The scientific program will include approximately 200 speakers representing specialists in all aspects of diseases of the heart and lungs. In addition to formal presentations, the program comprises a number of symposia, round-table luncheon discussions, diagnostic-treatment conference, and motion pictures. More than the usual time has been allotted for open discussion.

A new feature this year will be the fireside conferences, to be presented on Friday evening, June 3. At this session, more than thirty experts will be present to lead the discussions on as many subjects of current interest in the specialty of diseases of the chest.

Fellowship examinations will be held on June 2; and on Saturday evening, June 4, more than one hundred physicians will receive their fellowship certificates at the annual convocation which will precede the president's banquet.

All interested physicians are cordially invited to attend the meeting; there is no registration fee. Copies of the program may be obtained by writing to the Executive Offices, American College of Chest Physicians, 112 East Chestnut Street, Chicago 11, Illinois.

PHYSICIANS WANTED

A woman associate physician is wanted for the student health service of Ohio University, Athens, Ohio, starting September 15, 1955. The university is a coeducational state university with a student body of 5,500. There are three other full time physicians on the staff. For further details write: Director of Health Service, Ohio University, Athens, Ohio.

* * *

Woman physician wanted. Associate in ophthalmology, board qualifications not necessary, but basic training in ophthalmology required. For further information write Arthur E. Schultz, M.D., 119 E. Grand River Avenue, East Lansing, Mich.

* * *

Ball State Teachers College desires a woman physician, interested in education, as director of the college health service, July 1, 1955. The college is among the top five or six teachers' colleges in the United States. The work consists of health examinations of new students, of seniors, and others, for teacher licenses, and of graduate students and of employees; follow-up of remedial conditions found on student examinations; outpatient and infirmary care; and emergency care for faculty and employees. Beginning salary is $7,500 to $8,000, depending on education and experience. For further information write: John R. Emens, President, Ball State Teachers College, Muncie, Indiana.

RADIOLOGY CENTER

The University of Pennsylvania recently received a grant of $750,000 from the Donner Foundation to establish a radiology center at the university hospital. The major activities of the center will include the diagnosis and treatment of disease, investigative work, and an instructional program to train young men and women in the use of radiologic techniques. Physicians, chemists, and physicists will carry on cooperative research projects in the fields of radioactive isotopes, high energy radiation, and similar projects with special significance in the field of medical sciences.

COURSE

A course in the neuromuscular diseases of children with special emphasis on cerebral palsy will be offered by Dr. Meyer A. Perlstein at the Cook County Graduate School of Medicine in Chicago beginning June 20, 1955. Tuition for the course is $225 which includes the costs of luncheons during the course and the cost of transportation and hotels during itinerant clinics. Registration, which is limited, may be made by applying to the Registar, Cook County Graduate School of Medicine, 707 South Wood Street, Chicago, Ill.

ALBUM OF WOMEN IN MEDICINE

ESTHER M. GREISHEIMER, Ph.D., M.D.

ESTHER M. GREISHEIMER, Ph.D., M.D., was born on October 31, 1891, at Chillicothe, Ohio. She now lives in Germantown, Pennsylvania. She received her Bachelor's degree from Ohio University, in Athens, Ohio, in 1914; her Master's at Clark in Worcester, Massachusetts, in 1916; and her Ph.D. from the University of Chicago, in 1919. Her major was physiological chemistry and her minor was physiology. In 1923, she received her M.D. degree from the University of Minnesota. Instead of serving an internship, Dr. Greisheimer did research and teaching at the University of Minnesota until 1935.

In 1927, Dr. Greisheimer spent six months doing research in Europe. She spent three months in Berlin with Max Cremer, studying voluntary nerve impulses; and three months in London at the University College with Lovatt-Evans, studying glycogen formation.

While at the University of Minnesota, Dr. Greisheimer became associate professor of physiology. In the fall of 1935, she went to Woman's Medical College as professor of physiology, where she remained for eight years. From July to December 1943, Dr. Greisheimer was a resident in anesthesiology at the University of Minnesota Hospital. She then went to Temple University as professor of physiology, where her time is devoted to teaching and research. Her present project is studying cardiac output under different types of anesthesia by means of the Cuvette oximeter. She has just finished a completely revised and reset seventh edition of her textbook, "Physiology and Anatomy" (Lippincott) which is widely used by colleges and schools of nursing. It was off the press in April.

Dr. Greisheimer has a total of 120 scientific publications. She is a member of numerous scientific societies among which are the following: the American Physiology Society, The American Association for the Advancement of Science, The American Medical Association, The Philadelphia Anesthesia Society, Sigma Xi, Alpha Omega Alpha, Phi Beta Kappa, Sigma Delta Epsilon, and The New York Academy of Sciences. In January 1955, Dr. Greisheimer began her service as a deaconess at the First Presbyterian Church of Germantown, Philadelphia.

Dr. Greisheimer has taken a very active interest in the women medical students at Temple University. She entertains them in her home and is an advisor to them. Dr. William N. Parkinson, dean of Temple University Medical School, states that "without Dr. Greisheimer as a member of our faculty, I feel that our service to the women medical students would be handicapped."

Dr. Greisheimer was chosen as AMWA Branch Twenty-Five's "Woman of the Year" because, in the opinion of the committee, 1) of her outstanding scientific achievement; 2) of her excellent teaching; 3) of her work with women medical students at Temple University; 4) of her active interest in the Philadelphia Branch of AMWA; and 5) of her constructive interests in civic affairs.

—ELIZABETH B. BROWN, M.D.

News of Women in Medicine

DISTRICT OF COLUMBIA. Dr. Jeanne C. Bateman of Washington, D.C., spoke before the monthly meeting of the Prince George County Medical Society on February 1, 1955. The subject of her discussion was the treatment of cancer with new chemotherapeutic agents.

Dr. Bateman has been invited to discuss her work in cancer chemotherapy at the Radiumhemmet in Stockholm, Sweden, during March 1955, at the invitation of Dr. Sven Hultberg, Director of Karolinska Institute. While in Europe she will visit cancer hospitals in Germany and Italy.

Dr. Bateman, a consultant in oncology at The Garfield Memorial and St. Elizabeth's Hospitals, has been appointed a consultant to the Army Medical Corps. She will help in the preparation of a bibliography on the chemotherapy of cancer.

A series of radio programs on "Challenge of Good Medical Care" is being produced by the George Washington University and is presented over radio station WGMS. Recently, Dr. Irene Tamagna, director of the medical integration and rehabilitation unit of the University Hospital, was chairman of a panel discussion on "Rehabilitation."

The George Washington University presented its tenth annual series on intensive postgraduate courses. Dr. Pearl Holly spoke on "Abnormalities of Blood Coagulation of Importance to the Surgeon" and "Diagnosis and Treatment of Hemorrhagic Diseases." . . . "Dysmenorrhea" was the topic discussed by Dr. Shirley Sue Martin. . . . Dr. Ruth Hechler Wichelhausen was moderator of a symposium on Rheumatic Diseases. . . . Dr. Irene Tamagna participated in a round-table discussion on Diagnosis, Treatment, and Rehabilitation in Rheumatic Diseases.

ILLINOIS. Dr. Mila Pierce, of the University of Chicago, has been named a medical adviser of the Hematology Research Foundation.

MINNESOTA. Dr. Adelaide M. Johnson, of Rochester, Minnesota, was in New York recently to attend a meeting of the American Psychoanalytic Association. She served as chairman of a panel discussion of psychotherapy.

Dr. M. Elizabeth Craig was elected secretary-treasurer of the Asbury Methodist Hospital of Minneapolis.

NEW JERSEY. Dr. Louise Rowe is a member of the postgraduate course committee for the annual postgraduate course in diseases of the chest. This course is sponsored by the Council on Postgraduate Medical Education and the New Jersey Chapter of the American College of Chest Physicians.

NEW YORK. Dr. Ada Chree Reid, attending cardiologist of the New York Infirmary and member of speaker's bureau of the New York Heart Association, discussed "Heart Disease, 1955" at a meeting of the Wall Street Business and Professional Women's Club on Tuesday, February 15.

A conference on Reserpine in the treatment of neuropsychiatric, neurologic, and related clinical problems was presented by the New York Academy of Sciences. Dr. Ruth Martin of the Duke University School of Medicine, Durham, North Carolina, discussed the topic "Pre-Operative Sedation with Reserpine."

OHIO. Dr. Margaret Peeples, Columbus, urged that a mental hygiene clinic be formed, and that improvements be made in transportation for medical care, in her talk to the members of the Rosemont (Columbus) P.T.A. Dr. Peeples stressed that the Muscogee County Board of Education had already done much to improve the environment of schools to benefit the children, but that several more facilities were needed.

Woman's Medical College

Dr. Elizabeth V. Lautsch, of McGill University, has joined the faculty as associate in pathology. Dr. Gehard Giebisch, on leave of absence from the Department of Physiology at Cornell Medical School, has joined the faculty as research associate with Dr. Phyllis A. Bott, professor of physiological chemistry, for the remainder of the year.

Dr. Beatrice M. Joly, professor of surgery, at University College, Ibadan, Nigeria, visited the Woman's Medical College on February 9. Dr. Joly is visiting the United States under the Carnegie Corporation and the Fulbright Commission.

Research fellowships from the United States Public Health Service, four grants of $400 each, have been assigned to medical students as follows: Mary Lou Soentgen, "Studies on the Influence of the Pituitary-Adrenal System in Gastric Secretions"; Dorothea Johnson, "Isolation of Mitochondria from Bacterial Cells by Immunological Methods"; Charlotte Sokol, "The Significance of Serum Iron Levels in Gastric Carcinoma, Peptic Ulcers and Other Neoplasms"; and Zena Linden, "Epinephrine and Nor-Epinephrine in the Human Adrenal."

Dr. Maria Valdes-Dapena (Molly Brown) is director of the laboratory and assistant professor of pathology at the Woman's Medical College. Her husband, Dr. Antonio Valdes-Dapena, is pathologist and director of the laboratory at the Graduate Hospital of the University of Pennsylvania.

General

The Western Society for Clinical Research held its annual meeting in Carmel, California. Thirty-seven papers were presented. Dr. Marcelle F. Dunning and Dr. Fred Plum of Seattle, Washington, discussed "Potassium Washout by Enemas."

Dr. Sara M. Jordan of Boston, Massachusetts, was one of the guest speakers at the sixty-sixth annual session of the Mid-South Postgraduate Medical Assembly, which convened in Memphis, Tennessee.

Dr. Theresa Ting Woo is the recipient of a postgraduate scholarship awarded by Harvard University School of Public Health to prospective public health leaders. Dr. Woo received her medical degree from the University of Michigan School of Medicine in 1934. She has taken postgraduate study at the University of Chicago and at the School of Tropical Medicine of the Army Medical Center. During World War II, she served in the Medical Corps of the U. S. Army as a research analyst in the Medical Intelligence Division of the Surgeon General's Office. For a while she practiced in Washington, but returned to Army duty and as a Major served in the Army Hospital at Fort Belvoir, Virginia.

International

Great Britain. At a meeting of the University Council, London, Dr. Isabella G. Monypenny was appointed part-time instructor in anesthetics.

Dr. Margaret M. Platts was appointed to the J. G. Graves Medical Research Fellowship.

Prof. Dorothy S. Russell, director of the Bernhard Baron Institute of Pathology at the London Hospital, has been elected into a supernumerary fellowship of Girton College, Cambridge.

Recently, at the Institute of Laryngology and Otology, London, Miss Edith Whetnall, F.R.C.S., director of the audiology unit at the Royal National Throat, Nose, and Ear Hospital, held a clinical meeting for general practitioners at which the whole question of the recognition and management of the deaf child was discussed. Much of what Miss Whetnall said had relevance also to the special problem of the deaf-blind child.

The Royal Society of Medicine announces the award of the W. J. Harrison Prize in otology to Miss M. R. Dix, of the Otological Research Unit at the National Hospital for Nervous Diseases.

Dr. Mary Esslemont of Aberdeen, Scotland, is a member of the newly formed Scottish Council of the College of General Practitioners.

PICTURE CREDIT
Page 180—Courtesy of Savoy Studio, Philadelphia

THESE WERE THE FIRST

Dr. Lucy Hughes-Brown of North Carolina graduated from the Woman's Medical College of Pennsylvania in 1894, and received her medical license in Wilmington, North Carolina, the same year. Later she moved to Charleston, South Carolina, and was instrumental in establishing the Cannon Hospital and Training School. She is said to have been the only Negro woman physician in South Carolina at that time.

Dr. Helen Brooke Taussig received her medical degree in 1927 from the Johns Hopkins School of Medicine where she now is associate professor of pediatrics and also physician in charge of the cardiac clinic of the Harriet Lane Home. Dr. Taussig has many firsts in her record: She was the first woman elected to the Association of American Physicians, the first woman to receive the medal of the American College of Chest Physicians (1953), and, with Dr. Alfred Blalock, the first woman to receive the Passano Foundation award, in 1948. Dr. Taussig also has received the award of the National Women's Press Club, the Mead-Johnson award, the Legion of Honor medal (1947), and an honorary degree from the Boston University School of Medicine. With Dr. Blalock, Dr. Taussig has developed the successful operation for the correction of congenital pulmonic stenosis, and her publications are accepted as authoritative.

Dr. Anna Ross Lapham, graduate of Northwestern University Woman's Medical School in 1896, was the first woman appointed to the faculty of that institution where she is assistant professor of obstetrics emeritus.

Dr. Sara Mu Jin Ching, graduate in 1921 of the Woman's Medical College of Pennsylvania, was the first woman to receive the Boxer Indemnity fellowship to study medicine. Born in 1893 in Honolulu, Dr. Ching served as a volunteer doctor with the guerrilla movement in the Philippines, and lost her life during an attack by bandits. Previously she had taught at the Yale-in-China Medical School, Changshe, China, and for two years (1926-1928) was on the staff of the Worcester State Hospital, Massachusetts, and later at St. Elizabeth's Hospital in Washington, D.C. Her husband, Dr. Caesaro De Ching, was with the Cagayan Mission Hospital, Mindanao, and was later a medical officer with the Philippine Medical Corps. During her husband's internment by the Japanese, Dr. Sara Ching served with the undefeated guerrillas.

—Elizabeth Bass, M.D.

Book Notices

EDITOR'S NOTE: These reviews represent the individual opinions of the reviewers and not necessarily those of the members of the Editorial Board of the JOURNAL.

THE EFFECT OF ACTH AND CORTISONE UPON INFECTION AND RESISTANCE. Symposium held at the New York Academy of Medicine, March 27 and 28, 1952. Edited by Gregory Shwartzman, M.D., Mt. Sinai Hospital, New York. Pp. 204. Price $5.50. Columbia University Press, New York, 1953.

This excellent monograph presents the most recent aspects of the role of steroid hormones of the adrenal gland in resistance and infection. Not only are various infectious diseases included, such as tuberculosis, syphilis, poliomyelitis, and trypanosomiasis, but also important phases of allergic diseases are stressed.

An introductory chapter on the role of the adrenal cortex in intermediary metabolism is well-written. A chapter on the effect of adrenalectomy, splenectomy, and cortisone on the enzymatic reactions of the rat is included. Sections on lymphoid tissue, loose connective tissues, and tumor grafting are also found. There is a very well-presented discussion on the development of antibodies and hypersensitivity.

With the rapid advances in our knowledge of the adrenal gland, the importance and desirability of such monographs cannot be overemphasized. The combined work of 31 authors compressed into a little over 200 pages is a tribute to the editorial board of the New York Academy of Sciences who were responsible for this monograph. Each chapter is followed by a bibliography, so that reference to a more complete article may be found. The paper and printing is of the highest quality. This monograph will serve as a useful reference for internists, endocrinologists, and physicians interested in immunology and infectious diseases.

—Abraham M. Frumin, M.D.

PRACTICAL PHYSIOLOGICAL CHEMISTRY. By Philip B. Hawk, Ph.D., Sc.D. (Hon.), President. Food Research Laboratories, Inc., Long Island City, New York; Bernard L. Oser, Ph.D., Director, Food Research Laboratories, Inc., Long Island City, New York; and William H. Summerson, Ph.D., Chief, Biochemistry Division, Chemical Corps Medical Laboratories, Army Chemical Center, Maryland. Thirteenth Edition. Pp. 1,384, illustrated. Price $12.00. The Blakiston Company, Inc., New York, 1954.

It is rare indeed that a widely used scientific book appears through a number of editions over a period of fifty years, always with the same authorship. This is now the case with the appearance in 1954 of the thirteenth edition of this work by Dr. Hawk and his collaborators. Moreover, this golden anniversary edition contains ample evidence that the authors have attempted to keep the book abreast of the advances in biochemistry, both by the inclusion of new subjects and in revision of old material. References to articles and books of 1952 and 1953 and occasionally to those of 1954 appear in the bibliographies at the end of each chapter and in the numerous footnotes scattered throughout the text.

As in the twelfth edition, Dr. Hawk's coauthors are Dr. Bernard L. Oser and Dr. William H. Summerson. Even with three authors working closely together, the task of revising such a book must be formidable. For this reason, it is of special interest that there is now included a list of 31 distinguished biochemists who have acted as collaborators. In addition, 13 experts and teachers, all authorities in certain fields, have given assistance in the preparation of this volume. All of these individuals are acknowledged by Dr. Hawk in the preface.

The familiar frontispiece of earlier editions has given way to a color plate showing a two-dimensional chromatogram of a protein hydrolysate and illustrating a new section on paper chromatography. Certain chapters, mainly those on nucleoproteins, milk, muscular tissue, enzymes, and isotopes have been largely rewritten. Clinicians will be pleased to learn that sections on liver function and microclinical procedures have been added. The over-all proportion of textual material (as distinguished from experimental procedures and interpretations) stands at approximately 50 percent.

The dedication, "to the memory of Lafayette B. Mendel," seems eminently fitting in view of the late professor's great influence upon a number of editions of this book. It was not only the course in physiologic chemistry which Dr. Hawk took at Yale University, but the "spark of inspiration" which Professor Mendel generated there which furnished inspiration to carry Dr. Hawk through twelve revisions of this book.

Students of physiologic chemistry and workers in related fields who have long used the previous editions of "Practical Physiological Chemistry" will find this new edition of even greater value.

—Miriam F. Clarke, Ph.D.

A SOURCE-BOOK OF MEDICAL TERMS. By Edmund C. Jaeger, D.Sc., Formerly Head, Department of Zoology, Riverside College, Riverside, California. Forward by Irvine H. Page, M.D., Director, Research Division, Cleveland Clinic Foundation, Cleveland, Ohio. Pages 145, illustrated. Price $5.50. Charles C Thomas, Springfield, Illinois, 1953.

This volume should receive a warm welcome from the host of present-day students who come to medical schools from colleges which emphasize square dancing and football as more "modern" subjects for education than Latin and Greek. Such unfortunates will here discover that medical terms need not be meaningless burdens upon the memory. Each such name has its fascinating history: the word often defines itself if the classic root is known.

Dr. Jaeger is to be congratulated on the way in which he has summarized Latin and Greek inflections and terminations into a few pages. Nor does he neglect Germanic, Old English, and other roots. With this book, the student who has never taken courses in the classics will catch some faint glimpse of what he has missed. The more fortunate old-timer, who labored

over "All Gaul is divided into three parts," will discover gems of erudition he never noted before.

The brevity necessary in a work of this kind sometimes forces Dr. Jaeger to limit his account of a word's history to such an extent that we feel the loss of much of the romance of the term's story. Take the word "labyrinth," which is defined merely as a "maze." Right, as far as it goes: but this word derives from the Greek "labrys," a double-headed axe. That was the sacred symbol of the Minoan Zeus carved all over the vast maze of the palace at Knossos, in ancient Crete. The word brings to mind all the romance of Theseus, the Minotaur, Ariadne, and the rest.

The preface to the book explains why eponyms have not been included. It is said that terms involving the names of people are sufficiently treated in the standard dictionaries. The reader regrets this decision. The host of names, including Scarpa's Triangle, Friedreich's Ataxia, Kernig's Sign and so forth, *ad infinitum*, is vast and difficult to remember. The dictionary may give the definitions. This book might well give us brief accounts of the men whose names have become incorporated into our medical vocabulary.

—Joseph T. Smith, M.D.

MECHANISMS OF UROLOGIC DISEASE. By David M. Davis, M.D., Professor of Urology Emeritus, Jefferson Medical College; Visiting Lecturer in Urology, Graduate School of Medicine, University of Pennsylvania. Pp. 141, 6 figures. Price $4.50. W. B. Saunders Company, Philadelphia, 1953.

Written with the simplicity of a travel guide, this short manual covers the field of practical urology with the same thoroughness and dispatch. Obstruction, infection, stone formation, neoplasms, congenital abnormalities, trauma, foreign bodies, neurologic changes, male infertility, scrotal lesions, and lesions of the external genitalia are discussed in an orderly manner as to etiology, functional pathology, diagnosis, and therapy. Final chapters outline history taking and catheterization.

Designed initially as introductory lectures for the third medical year, the book now stands not only as a syllabus for students but also a manual for practitioners of all ages who will find much to learn or relearn in its few but succinctly worded pages. Some charts are included, and carefully selected reading references round out a well-organized and comprehensive distillation of urologic knowledge and experience.

—Margaret H. Edwards, M.D.

DISEASES OF THE KNEE: MANAGEMENT IN MEDICINE AND SURGERY. By Anthony F. DePalma, M.D., James Edward Professor of Orthopedic Surgery and Head of the Department, Jefferson Medical College, Philadelphia; Chief Orthopedic Surgeon (Rotating), Philadelphia General Hospital; Consultant Orthopedic Surgeon, Veterans Hospital, Philadelphia. Pp. 840, 455 illustrations, Drawings by Carl Brill. Price $20.00. J. B. Lippincott Company, Philadelphia, 1954.

This new book is a worth-while volume for anyone practicing clinical medicine. Few authors could cover the subject of the knee joint so thoroughly in one volume. The book is well-organized and has many good photographs and diagrams to help clarify various subjects.

Dr. DePalma describes the evolution and comparative anatomy of the knee joint, as well as its physiology, anatomy, and mechanics. For anyone to understand and treat knee conditions properly, it is necessary that he know these basic principles, and they are well presented here. The lesions of each anatomic part are then covered quite thoroughly with a fine clinical approach for correct diagnosis and treatment. One fact which is important, but is often neglected or forgotten, is emphasized repeatedly: namely, the importance of the quadriceps muscle in the rehabilitation of the knee. Dr. DePalma also emphasizes that surgical procedures are not the complete treatment for many knee lesions. For a restoration of knee function, the postoperative treatment is just as important as the surgery. As is pointed out, patellectomies, even the most successful, do weaken the knee joint and they should be done only when absolutely necessary.

Another feature of this fine book is the presentation of the progressive degenerative changes of the knee joint. With our population becoming generally older, more attention should be paid to these changes.

—Walter R. Peterson, M.D.

SURGICAL FORUM: Proceedings of the Forum Sessions, Thirty-Eighth Clinical Congress of the American College of Surgeons, New York City, September 1952. Surgical Forum Committee: Owen H. Wangensteen, M.D., F.A.C.S., Minneapolis, Chairman; J. Garrott Allen, M.D., F.A.C.S., Chicago; Warren H. Cole, M.D., F.A.C.S., Chicago; Robert E. Gross, M.D., F.A.C.S., Boston; Carl A. Moyer, M.D., F.A.C.S., Dallas; I. S. Ravdin, M.D., F.A.C.S., Philadelphia; H. B. Shumacker, M.D, F.A.C.S., Indianapolis. Pp. 716, illustrated. Price $10.00. W. B. Saunders Company, Philadelphia, 1953.

There are in this volume papers of great interest touching on almost all the important aspects of surgery. The great percentage of papers deal with laboratory and experimental work. All are, however, of direct importance to the clinical management of the surgical patient. Those on cardiovascular subjects are particularly interesting and significant.

This volume will be of special interest to the surgeon and should be read particularly by the general surgeon who is not in frequent contact with teaching and experimental centers, as well as by residents and house officers.

—John S. Wise, M.D.

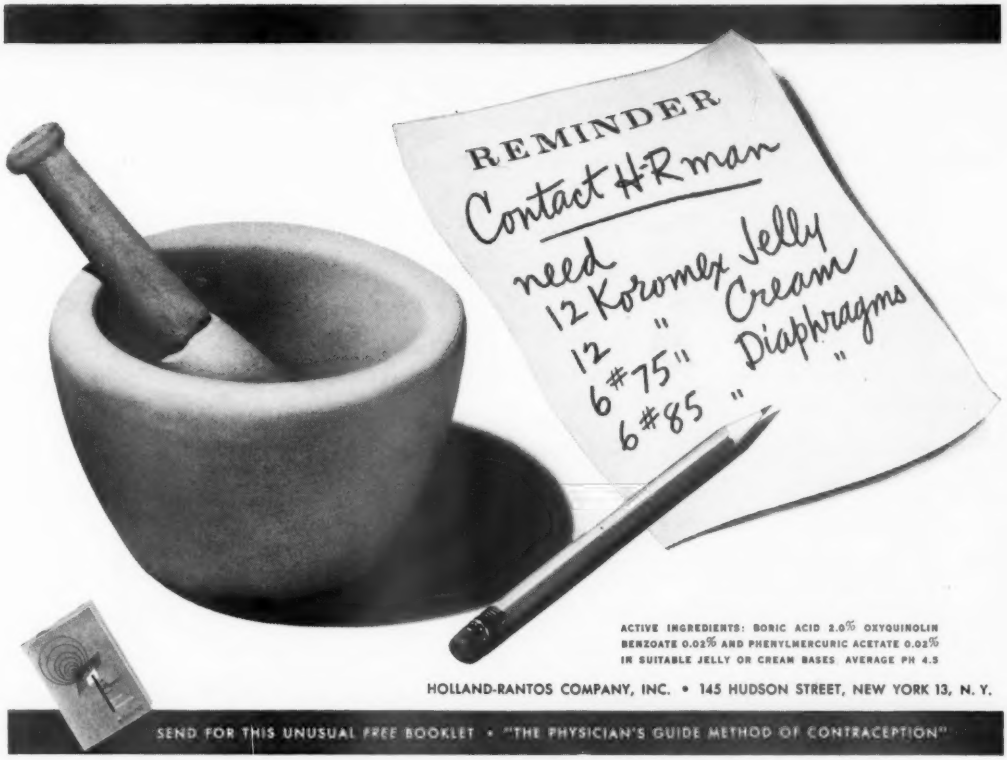
A MANUAL OF TROPICAL MEDICINE. By Thomas T. Mackie, M.D., Colonel, M.C., A.U.S. (Retired), Chairman, The American Foundation for Tropical Medicine; George W. Hunter, III, Ph.D., Colonel, M.S.C., U.S.A., Chief, Section of Parasitology-Entomology, Fourth Army Area Medical Laboratory, Brooke Army Medical Center, Fort Sam Houston, Texas; and C. Brooke Worth, M.D., Field Staff Member, Division of Medicine and Public Health, The Rockefeller Foundation. Second Edition. Pp. 907, 304 illustrations, 7 in color. Price $12.00. W. B. Saunders Company, Philadelphia, 1954.

This book deals with its material in a clear, concise manner. Its organization and style make for easy reading and reference. Indeed, it seems to be more than a manual.

The fact that this work has been brought up to date is attested to by the chapter on Epidemic Hemorrhagic Fever. The latter, as is the case in most of the diseases considered, is given much more space than is usual in a manual.

This volume seems to have been designed specifically for the busy practitioner and student. It should be most useful for study and reference.

—Victor A. Digilio, M.D.



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EDITORIAL FORECAST

June 1955

Dr. Esther Bartlett is the Guest Editor for the special New England Hospital issue of the JOURNAL, appearing in June. A variety of articles will be presented, and material about the history of the hospital and of medical women in New England.

"Recent Advances in Surgery: Clinical Applications of Enzymes," by Annella Brown, M.D.

"Thyroid Function in Infant with Congenital Goiter," by Clara Waldinger, M.D., M.P.H., Olga S. Wermer, M.D., and Edna R. Sobel, M.D.

"Treatment and Rehabilitation of Alcohol Addicts in a General Hospital Setting," by Martha Brunner-Orne, M.D.

"Evidence of Esophageal Hernia in Chest Photofluorographic Surveys," by Marion Perry, M.D.

There will be a History of the New England Hospital by Felicia A. Banas, M.D., and "Fund Raising and Public Relations in Voluntary Hospitals," by Carolyn K. Winters, R.N.

"Please!" by William H. Woglom, M.D., is an editorial concerning medical writing.

A second interim report from the Legislative Committee is entitled "Social Security for the Doctor," and is by a member of the committee, Elizabeth A. McGrew, M.D.

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Article III, Section 1a. **Active Members** "shall be members of a Branch, if any local Branch exists; if not, they may be Members-at-large."

Article III, Section 6. **Associate Members** "shall be: (1) Medical women in the first year of practice; (2) women interns, residents-in-training, and fellows. Associate members shall not pay dues and shall have all privileges of memberships, except voting, holding office, and membership in the Medical Women's International Association."

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OATMEAL
BARLEY
CORN
CEREAL FOOD

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We have been advised—

"AMWA delegates requiring sleeping rooms during the American Medical Association convention can reserve such accommodations *by writing directly to the Reservations Department of THE DENNIS specifying their departure date as not before June 9.* Upon receipt of this reservation, a confirmation will be sent requesting a good faith deposit which will be applied against the room occupancy charge on the nights of Tuesday, June 7, and Wednesday, June 8."

—JOHN E. LEISHMAN, *Director of Sales*
Hotel Dennis, Atlantic City

The Dennis urges that AMWA reservations for June 2-5 be made at once. Demands for AMA reservations make this imperative.

For AMWA reservations use the blank below.

HOTEL DENNIS **June 2 through 5, 1955** **ATLANTIC CITY, N. J.**

ANNUAL MEETING 1955

Mr. John E. Leishman,
Director of Sales,
Hotel Dennis,
Atlantic City, N.J.

Please acknowledge reservations as follows for the A.M.W.A. Annual Meeting:

Single room: $8——; $9——; $10——

Twin Bedded room: $12——; $14——; $16——; $18—— (all rooms with bath)

Double and Single with connecting bath (3 persons) $18——

(Plus 3% sales tax on all rates)

Indicate price preferred.

I shall arrive on ———— and depart on ————

Name ————

Address ————

If reservation is for more than one person, please state name(s) and address(es) of other person(s).

Name ———— Address ————

Name ———— Address ————

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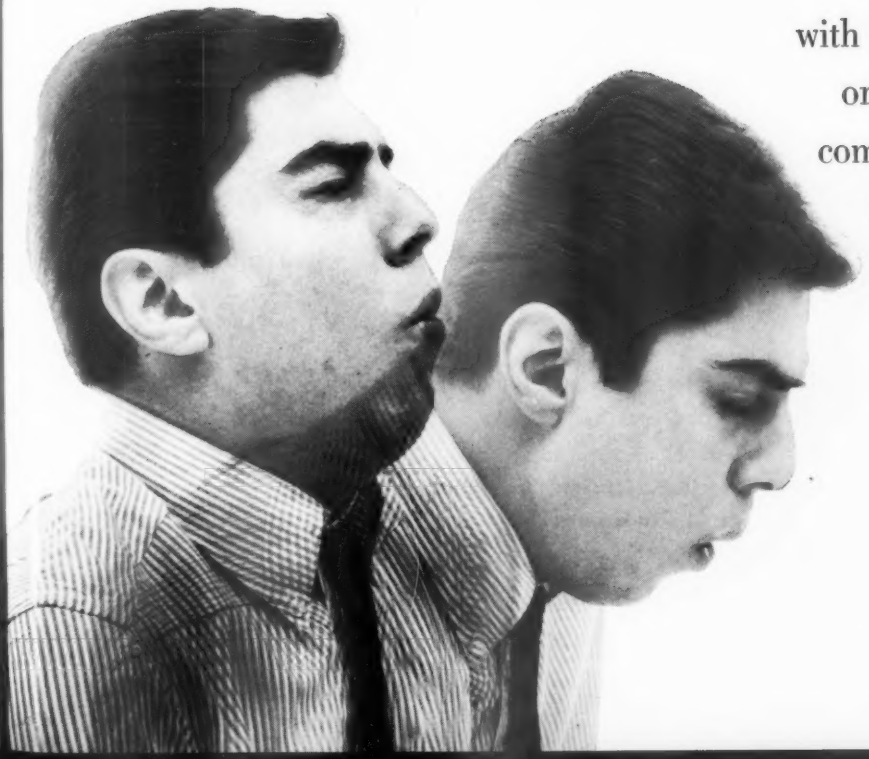

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ATTENTION, A M W A MEMBERS!

The advice of AMWA members is urgently needed.

Please answer the questions below regarding the terms of office for your Association officers, and

Send your answers at once to the

AMERICAN MEDICAL WOMEN'S ASSOCIATION
Room 409, 1790 Broadway
New York 19, New York

Your answers will guide the discussions of the

COMMITTEE ON CONSTITUTION AND BY-LAWS

THIS IS NOT A BALLOT

AMERICAN MEDICAL WOMEN'S ASSOCIATION
Room 409, 1790 Broadway
New York 19, New York

I would like to have—

	yes	no
1 The President and President-Elect serve for a term of two years	☐	☐
2 All officers eligible for re-election for a consecutive term of one year	☐	☐
3 Our present election procedure continued—i.e., the President, President-Elect, Vice-Presidents, and Secretaries serve for a term of one year each	☐	☐

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The Improvised Hospital of the Federal Civil Defense Administration will be exhibited in Convention Hall at Atlantic City, from June 4 through June 10.

This Hospital, designed by the Federal Civil Defense Administration, is a complete 200-bed unit hospital, transportable on a single tractor-trailer truck. It weighs approximately 13.5 tons, contains some 288 different items, and will take up some 2,000 cubic feet for storage. It can be assembled in about four hours by about thirty professionals and trained and untrained auxiliaries, requiring a minimum of some 15,000 square feet of floor space. The Hospital costs $26,500. The Federal Civil Defense Administration is stockpiling these hospitals which are available to the states on a matching-fund basis.

This should be interesting to physicians active in Civil Defense affairs, since little, if any, authoritative data have been available to the medical profession on the care and treatment of persons exposed to external and internal radiation. Only recently, has the public been informed of the extensive and lethal effects that may be expected from "radioactive fall-out" created from an A- or H-bomb attack.

Arrangements for exhibiting the Hospital were made by the Council on National Defense of the American Medical Association, who epecially urge all women physicians to take an active part in Civil Defense preparations.

ANNUAL MEETING

HOTEL DENNIS ATLANTIC CITY

Reservations for Luncheons and Dinners

Enclosed is my check for $_____ to cover advance meal reservations for the Annual Meeting as checked below:

Friday, June 3

_____Luncheon $4.00
_____Woolley Dinner $7.50

Saturday, June 4

_____Program Preview Luncheon.....$4.50
_____Inaugural Dinner $7.00

Gratuities are included in above prices.

Name....., M.D.

Address.....

Please make checks payable to the American Medical Women's Association, Inc.

Mail to American Medical Women's Association, Inc., 1790 Broadway, New York 19, N.Y.

Checks cannot be accepted at above address after May 30, 1955.

Please make all reservations promptly.

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(Continued on page 36)

HISTORICAL INFORMATION

For the Establishment of Permanent Historical Records Concerning Members of the American Medical Women's Association

Name..... Address.....
City..... State.....
Single.....Married.....Widow.....Children.....
College..... Graduation year.....
Graduate study..... Further degrees.....
What have you practiced?..... Where?.....
Organizations to which you belong..... Dates.....
Offices held.....
Institutions with which you are, or have been associated.....
.....
Hospital staff.....
Specialty.....Further study.....
Research.....
Other types of professional activities.....
Special clinical projects.....
Publications.....
.....
Honors.....
Civic activities.....

PLEASE COMPLETE AND RETURN TO: Ida J. Draeger, *Librarian,* Woman's Medical College of Pa., Henry and Abbottsford, Philadelphia 29, Pa.

Date..... Gulielma Fell Alsop, *Chairman,* Historical Committee

Lederle

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For preventing and treating Hyperemesis Gravidarum

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Average dose: 5 to 12 tablets daily, in divided doses, at times when vomiting is less likely to occur; or 1 cc. parenteral solution 2 or 3 times weekly.

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Tripolitania	Dr. Clelia Lollini	*Tripoli*
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December 31, 1954

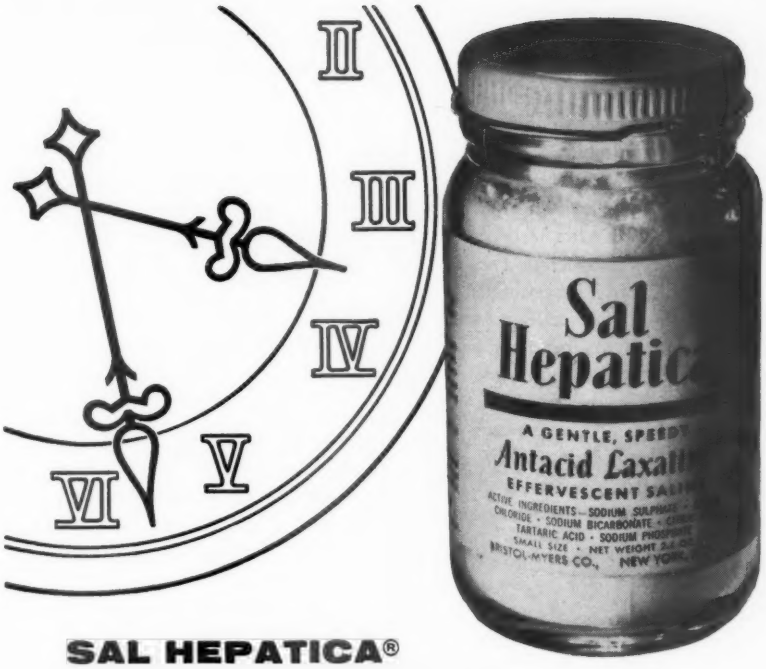
Please correct my listing in the directory to read as follows:

Name _____

Street _____ City _____

State _____ Specialty _____

As Compiled:
Names included: All members with dues paid on December 31, 1954
Addresses: As on file in the executive office
Specialties: As on file or listed in the AMA Directory—1950



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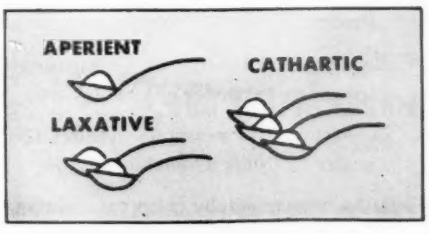
Thus SAL HEPATICA quickly leaves the stomach to enter the intestine where its laxative action takes place.



2. It stimulates intestinal peristalsis by its osmotic action. The fluid drawn into the intestine is a mechanical stimulus to evacuation, which usually follows promptly.

Prompt, gentle laxation without griping follows the use of pleasant-tasting SAL HEPATICA. The gastric hyperacidity so frequently accompanying constipation is relieved, too, because SAL HEPATICA is antacid.

References:

1. The Physiological Basis of Medical Practice. 1945. p. 486.
2. New England J. Med. 235:80, July 18, 1946.

ANTACID, EFFERVESCENT, SALINE LAXATIVE

BRISTOL-MYERS CO., 19 West 50 Street, New York 20, New York

IT HAS BEEN REPORTED—

Rheumatoid arthritis patients who had not responded satisfactorily to other medication, showed marked improvement without developing a proportionate increase in undesirable side effects when treated with relatively small doses of the new steroid Meticorten (Schering), according to Bunim and associates, reporting in *J.A.M.A.* (Jan. 22, '55). Similarly, Boland and Headley wrote of treating a series of 38 such patients with Meticorten. They observed (*California Medicine,* Feb. 1955, p. 69), "In general, the early observations confirmed those reported by Bunim and colleagues. These investigators found that a number of patients inadequately controlled by hydrocortisone have improved satisfactorily when transferred to small milligram doses of Meticorten." Comparative dosage studies, according to Dr. Boland and Dr. Headley, indicated the potency of Meticorten to be approximately 4.3 times that of hydrocortisone (free alcohol).

Appetite and interest in food can be stimulated in underweight and poorly eating children by using, as a food supplement, a pediatric milk fortifier containing lysine, an essential amino acid, according to Dr. Anthony A. Albanese, Chief of Nutritional Research of St. Luke's Hospital, New York, and his colleagues, Drs. Reginald A. Higgons, Gertrude M. Hyde, and Louise Orto, the chemist member of the team. Their first clinical report on the subject appears in the current April-May issue of the *American Journal of Clinical Nutrition.*

For 5 of 15 children body weight and nitrogen balances were markedly improved by the lysine supplement. Six of the 15 showed no spectacular weight gains, but urinalyses showed that more nitrogen was retained than before the lysine was added, indicating that these six gained in strength and sturdiness. Blood levels also increased during the study period. The remaining four infants whose growth rate was already well above average, showed no observable improvement when lysine was added to their diet, indicating that lysine-fortified diets are only effective with children who are not getting adequate nourishment from their food. Results of the studies imply that the nutritional value of many infant foods, including cow's milk, can be substantially improved by small additions of lysine. Furthermore, as Dr. Albanese points out, lysine fortification of milk increases its effectiveness in building muscle tissue in the infant and young child. He emphasizes that deficiency of lysine in the diet not only impedes the synthesis of muscle tissue but apparently is responsible for depression of appetite, in turn causing decrease in the intake of vital foods. Lysine fortification of milk seems to stop this vicious circle at the same time it improves utilization of ingested protein. A tasteless white powder that dissolves readily in milk and contains, besides lysine, all essential vitamins as well as iron and calcium is available to the medical profession under the name of Lactofort (White).

A black widow spider bite, causing the victim severe pain and muscular spasm, was treated with 60 units (9 mg.) of d-tubocurarine slowly given intravenously, when the patient was hospitalized six hours after being bitten. The treatment brought temporary relief, but when the symptoms returned four hours after the initial dose, a second dose was given, this time in 1,000 cc. of saline solution, administered over a period of three hours. Provided the usual precautions are taken, treatment with d-tubocurarine is effective for this type of poisoning. (*World Medical Journal,* 2:123, March '55.)

NEW EQUIPMENT

Bandaging—**'Super-Stick'** adhesive bandages by Johnson & Johnson

Bandaging — **Universal Band-Seal** by Caster Products

Blood pressure (to record) — **Automatic blood pressure recorder** by Colson Corp.

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Obedrin contains no artificial bulk, so the hazards of impaction are avoided. The 60-10-70 Basic Diet provides for a balanced food intake, with sufficient protein and roughage.

*Eisfelder, H. W.: Am. Pract. & Dig. Treat., *5*:778 (Oct. 1954).

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Journal of the
AMERICAN MEDICAL WOMEN'S ASSOCIATION

GENERAL INFORMATION

THE JOURNAL OF THE AMERICAN MEDICAL WOMEN'S ASSOCIATION is the official organ of the American Medical Women's Association and is issued monthly the fifteenth of each month.

CONTRIBUTIONS—THE JOURNAL OF THE AMERICAN MEDICAL WOMEN'S ASSOCIATION extends an invitation to the profession for articles on original investigation, for reviews, case reports, articles of historical interest—especially those dealing with the status of women physicians, biographies of women in medicine, and any other material on subjects of special concern to women physicians. All manuscripts for publication, letters, and all communications relating to the editorial management of the JOURNAL OF THE AMERICAN MEDICAL WOMEN'S ASSOCIATION should be sent to the Editor at the address below.

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REPRINTS—Reprints of all articles must be ordered at time proof is returned. Prices will be available for quotation from the Business Manager when articles are in page form. Individual reprints of articles must be obtained from the author.

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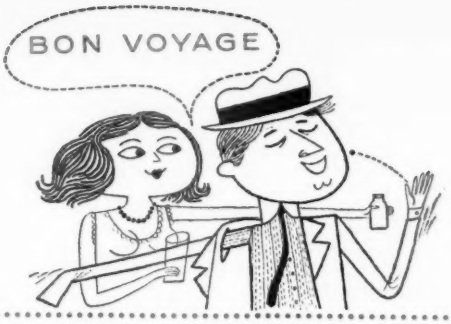
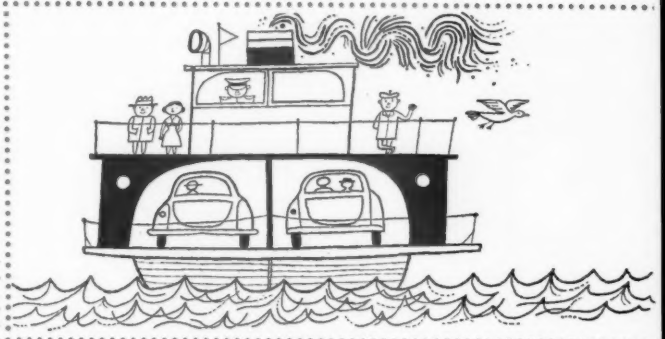
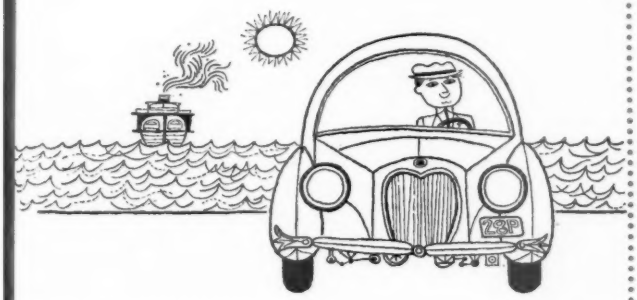
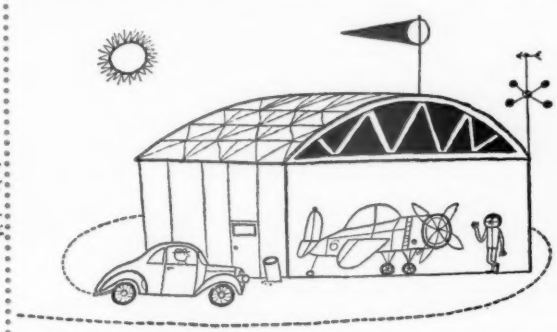


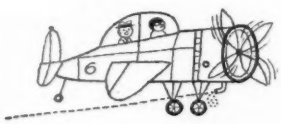






...a comfortable voyage now assured with **Bonamine*** HCl

BRAND OF MECLIZINE HYDROCHLORIDE



...the first motion-sickness preventive effective in a single daily dose

...prevents or relieves motion sickness due to all forms of travel

...available on prescription only for full physician supervision

Bonamine *is also useful in controlling the nausea, vomiting and vertigo associated with morning sickness of pregnancy, vestibular and labyrinthine disturbances, cerebral arteriosclerosis, radiation therapy and Menière's syndrome.*

Supplied in scored, tasteless 25 mg. tablets, boxes of 8 and bottles of 100 and 500. *TRADEMARK

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In 15, 30, and 60-cc vials with calibrated dropper, *dated* to insure full potency.

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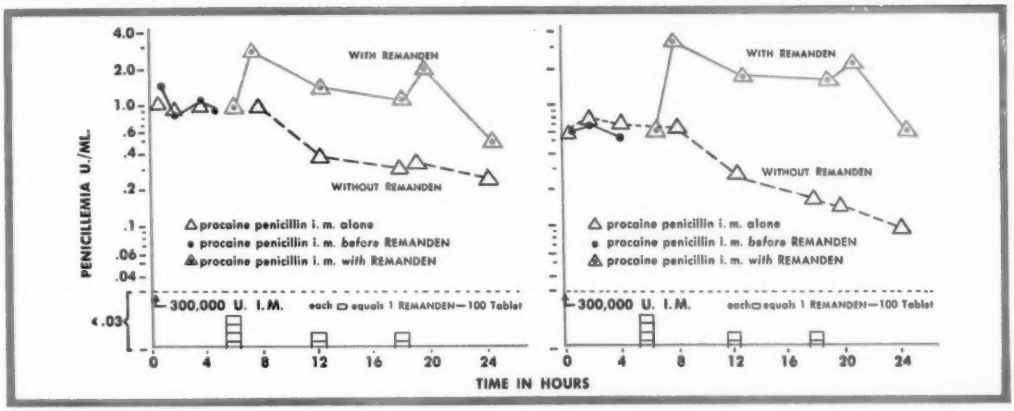
Remanden.®

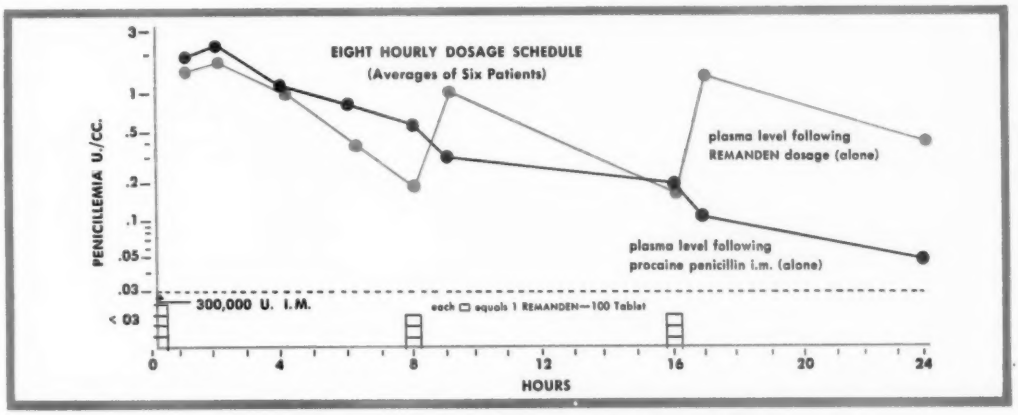
PENICILLIN WITH BENEMID®

for higher, more prolonged plasma penicillin levels

MAJOR ADVANTAGES: Plays two unique roles in oral penicillin therapy:
(1) Elevates and sustains initial intramuscular plasma penicillin levels,[1]
(2) Given alone, produces levels comparable to those of i.m. penicillin.[2]



REMANDEN raises and prolongs i.m. plasma penicillin levels.[1]



REMANDEN alone gives levels comparable to i.m. penicillin.[2]

REMANDEN extends the scope of penicillin therapy. Due to the 'Benemid' component, most of the penicillin is recirculated—without interfering with normal renal function. Unique among oral penicillin preparations, REMANDEN may be given alone in many common infections, or as an adjunct to parenteral therapy of more severe infections.

Supplied: REMANDEN-100 and REMANDEN-250 Tablets, providing 100,000 or 250,000 units of potassium penicillin G with 250 *mg.* of 'Benemid'. Also NEW Suspension REMANDEN-100 (in 60 cc. bottles)—one tsp. equals one REMANDEN-100 tablet.

References: 1. Scientific Exhibit, Norristown State Hospital: Data to be published. 2. Antibiotics and Chemotherapy 2:555, 1952.

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Liquid or Powdered

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An extra protein margin of safety for better tissue structure—optimal growth

20 Gm. protein	16 Gm. protein
Lactum formula for a 10-lb. infant	Recommended Daily Allowance for a 10-lb. infant

a protein margin of safety...plus

1. All the natural nutrients of whole milk.
2. Natural butterfat retained, no animal or vegetable fats substituted; perfectly homogenized.
3. Twice as much vitamin B_6 as breast milk.
4. Added Dextri-Maltose® permits gradual, spaced absorption; spares protein and helps metabolize fat.
5. Caloric distribution based on authoritative recommendations.
6. Curd tension practically zero, for exceptional digestibility.
7. Good height-weight curves, firm tissue structure, excellent blood pictures.
8. Stools normally soft, light-colored, without offensive odor.
9. Notable absence of undue hunger, regurgitation.
10. Both Liquid Lactum® and Powdered Lactum offer the maximum in convenience. They mix easily with water to make uniform formulas.

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